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PEPPER COMMISSION RECOMMENDATIONS ON UNIVERSAL HEALTH CARE

HEARING

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

ON

EXAMINING THE RECOMMENDATIONS OF THE PEPPER COMMISSION AND THE STEPS THAT SHOULD BE TAKEN TO IMPLEMENT ITS REPORT

APRIL 6, 1990

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PEPPER COMMISSION RECOMMENDATIONS ON UNIVERSAL HEALTH CARE

FRIDAY, APRIL 6, 1990

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 9 a.m., in room SD-430, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the committee) presiding.

Present: Senators Kennedy, Pell, Adams, Hatch, and Durenberger.

Also Present: Senator Riegle.

OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. The committee will come to order.

Today we face a crisis in the health care system that threatens the well-being of every American family. The challenge is more serious than at any time since the enactment of Medicare in 1965, and no one is immune—young or old, rich or poor, business or labor, city or farm, insured or uninsured.

In my view, health care should be a basic right for all, not just an expensive privilege for the few. My family has been fortunate in being able to obtain the best in health care, and it ought to be available to every family.

Yet there are 37 million Americans who have no health insurance at all, either public or private, and there are 60 million more with inadequate insurance. Fifteen million American families annually go without health care because they cannot afford it, and one-half of all people hounded by collection agencies are in debt because they have medical bills they cannot pay.

The crisis is not confined to the 100 million Americans who are uninsured or underinsured. Key health care institutions on which millions of Americans depend are on the verge of collapse. In New York City, the average wait in emergency rooms is three days before a patient can be admitted to the hospital. In Los Angeles, more than half the private hospitals have dropped out of the Los Angeles trauma care network that provides emergency services for the most seriously injured because they can no longer afford to care for uninsured patients.

Virtually every State in the country is reporting that patients are piled up in emergency rooms because of a lack of hospital beds. Forty percent of the Nation's hospitals fail to meet health and safety standards.

Whether a patient is rich or poor, insured or uninsured, these conditions have the potential to put life at risk. And even Americans that are fully insured today are just one paycheck, one job change, one management decision to drop insurance coverage from being out of luck tomorrow.

One of the most troubling aspects of the current crisis is the devastating impact on children. Every child in American deserves a healthy start in life, but too many fail to get it because their parents cannot afford it, and society will not provide it.

One in every five children in American today—12 million children in all—have no health insurance coverage. Two out of every three pregnant women who are uninsured do not get the low-cost, effective prenatal care that their babies need. It is no wonder that 18 other industrial nations have a better record of keeping babies alive than the United States.

Forty percent of our children do not even receive basic childhood vaccines. Studies out today indicate the spread of measles with life-threatening results for thousands of American children. American children are the innocent victims of the health care crisis, and that means that America is the victim, too, because our children are our future.

The crisis in health care is not only a health issue, it is an economic issue as well. The United States spends more than any other country on health care. We spend 40 percent more per capita than Canada, 90 percent more per capita than West Germany, and more than twice as much as Japan. No wonder the American firms are struggling to compete in world markets.

I believe that the time has come when universal health care and tough cost control measures can and must be enacted. I believe the American people are demanding action, and when the people lead, the politicians will follow.

Today we begin a series of cooperative hearings by the Labor and Human Resources Committee and the Finance Committee to develop a new comprehensive health care program on an accelerated basis. The members of a bipartisan work group involving key members of both committees have had over 20 meetings in the last ten months. This working group is committed to developing a solution to this problem and enacting it.

Our hearing today focuses on the recommendations of the Pepper Commission and the steps that should be taken to implement its report. The recommendations provide a solid basis for progress, and they are an appropriate way to launch this series of hearings.

I will say a brief word of introduction of our first witness after we hear from our colleagues.

Senator Hatch.

OPENING STATEMENT OF SENATOR HATCH

Senator HATCH. Thank you, Mr. Chairman.

I am delighted to join with you in today's hearing to review the Pepper Commission's report, or what I would just as soon call the "Rockefeller Commission's report" on "Access to Health Care and Long-Term Care for All Americans."

I applaud the diligent work of all the members of that Commission. Several Senators including you, Mr. Chairman, Senator Durenberger here, and our first witness, Senator Rockefeller, worked hard to produce this comprehensive report, and you faced a monumental challenge in finding options to expand access to health care. I want to personally express appreciation to the distinguished Senator from West Virginia for assuming that job and following through on it. Senator Rockefeller, you have done the very best you could and you continue to work, now that the recommendations are out, with the bipartisan group to try and resolve the various problems that still exist. I think Senator Rockefeller deserves a lot of credit, and that is one reason I came here today, but I wanted to thank him this morning.

The basic issue facing the Congress this year is how to ensure access to health care for all Americans. There are many Commissions and working groups attempting to put ideas on the table, and I encourage that; we all do. And I am pleased to work on the Labor Committee/Finance Committee Working Group on the Uninsured. While I hope that we can synthesize the viewpoints and ideas flowing from these groups and achieve some kind of consensus on how to expand access to health care, there are two fundamental differences that have been recurrent.

There is one group that advocates the view that if costs are reduced, health care will be more affordable, and more people will have entry into the health care system. Then there are those who believe that we should expand access to health care regardless of the cost and regardless of the negative impact on our health care system and on our economy. I suspect that the solution lies somewhere in between.

A majority of the members on the Pepper Commission, by a vote of 8-to-7, chose to adopt for the most part this second strategy on solving the problems of the uninsured. What was recommended was a "play or pay" package which would require employers to provide a set health insurance package to their employees. This, I believe, is the same as the mandated benefit approach, and most people know where I stand on mandated health benefit legislation. I believe it is too costly, I believe it will cost jobs, and I believe that it will reduce flexibility for employees to choose their own benefit packages.

Congressman Gradison in his dissent appropriately criticized mandates. He stated that "mandates are based on the notion that those employers, primarily small businesses, who do not offer health insurance are able, but unwilling, to offer health insurance." I have not found that to be the case.

Small employers are locked out of the health insurance marketplace for one primary reason: health care is simply not affordable. Health care costs are rising because of State-imposed benefit mandates for insurance, the increased costs of administering health insurance, medical liability costs, caused by the medical malpractice explosion, and overutilization of care and other factors.

Now, before we start blanketing more costs on the backs of America's workers and entrepreneurs and denying workers choices, I believe we should find some constructive ways to reduce health care costs. That is where we should spend our time, and I am committed to work with my colleagues toward this important objective.

In that regard, again, I want to say that this Commission has done its best to try and come up with an approach that would bring people together, and I believe it has taken more of a middle-of-the-road approach than has been suggested before. And, let me just say that I think the chairman of this committee has done the country a favor in raising this issue. He raised it in the context of mandated health benefits, and that is fine, because it has created a tremendous explosion of ideas, a tremendous discourse on this matter, and I think we've got the best people in the country working on it on all sides trying to bring us all together. And, that was one of the things that Senator Rockefeller and others have been trying to do not only during their Commission hearings, but also since. So I want to just express my appreciation for that.

This is a tough problem. There is no simple answer or set of answers to this problem, but I believe that the people who really are working in this bipartisan group, including our chairman, Senator Rockefeller, Senator Durenberger and others, are really, really dedicated to try and get this problem solved. I hope we can, and I hope the people who are listening to this hearing today and to the hearings in the future, those who are experts and who do have good ideas in this area, will get with us and help us to find the solution that will bring everybody together to help solve these serious problems in our society.

To that extent, I want to again compliment both our chairman and Senator Rockefeller for being willing to face this issue and to do the very best they can to elucidate it so that we might be able to possibly solve it.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Durenberger.

OPENING STATEMENT OF SENATOR DURENBERGER

Senator DURENBERGER. Mr. Chairman, thank you for the opportunity to be at this hearing. I am particularly pleased that Jay Rockefeller is going to be our lead witness. As you know, he did an incredible job that is not at all reflected in that famous 8-to-7 vote; there was a lot more consensus on the Commission on a variety of issues than that one vote reflects. And I trust that during the course of the hearing this morning, we are going to talk about a lot of the things that we all agreed on, and not just the things we disagreed on.

I am convinced that because of the year we spent together, there will come a day when the President of the United States will sign into law legislation that will establish universal access to health care in this country and to long-term care.

I think, Mr. Chairman, both you and Jay Rockefeller will be at the Rose Garden signing. The problem is one of you might be President by the time we get around to that. I'm not sure this is going to happen just like that. It is a very difficult subject as both of you have indicated, and simply understanding the nature of the problem is precedent to dealing with the solution.

I think the good, we did on the Commission was all of the things that we agreed on. I think we brought congressional leaders closer in their thinking than we had been when we just met over the reconciliation conference table.

I think our agreement that social insurance ought to supplement income for long-term care, for low-income moms' and kids' access to medical care is an incredibly important contribution that the Commission is making to the future of public policy. I think the commitment that we made in the direction of making providers more accountable to payment reforms and outcome guidelines and so forth was also very important.

The fact that the failings in the current system that drives costs are problems that exist today in the workplace, the over-reliance on health insurance as we had once known it, and that we ought to do something about that, is probably where the challenge of the future lies.

I voted against the Commission majority for many of the same reasons that my colleague from Utah stated—that I think a "play or pay" option on medical insurance is more than this country can afford; I don't think it is going to improve the quality of health care, and I don't think in the long run it is going to improve access to health care, because it does nothing about dealing with the issues of cost. There are too many people and too many employer groups in the workplace who cannot afford either health insurance or the alternative tax until we do something about the cost of medical technology, the cost of overutilization in the system, and the cost of providing services.

I would also like to point out that one of the failings I felt in the Commission's ultimate findings was its unwillingness to face up to the issue of the tax subsidies. We are real good at talking about how to deal with direct subsidies, and that we ought to put more subsidies under long-term care, tax subsidies under moms and kids and poor people, etc. But when it comes to the subsidies for the rich, when it comes to the subsidies for the overinsured, when it comes to the subsidies for the great big companies, we didn't have the nerve to take on that particular issue. When you have a $49 billion a year subsidy in terms of revenue foregone in both the income tax and the payroll tax, and a Commission like this doesn't say something about how that money ought to be spent, I think that is clearly a shortcoming, and I also think there probably are some short-sighted, near-term political reasons for not doing that—because we couldn't pass it, why talk about it.

But in the long-term, unless we deal with that particular issue, we are going to have difficulty finding the resources to deal equitably in this country with financing access.

And finally, Mr. Chairman, I think we have all concluded that the private health insurance system in our country is dead, if not dying, at least the way it currently operates. That is so evident in the individual and small group market. You can see it in the rush to self-insurance; you can see it in the breakdown of Medigap; you can see it in the breakdown of the FEHBP program. And if there is one area that we can get to work on fairly soon here in the Senate and in the House, it is reforming what we have come to call health insurance in this country. Perhaps through that mechanism we will begin to get some control over the cost of access in the system.

So I am here to congratulate the chairman of this committee who has been at this now for 28 straight years in this body, and the chairman of the Pepper Commission who has been at it for a couple of years and one year very intensively, for making the country face up to this problem.

Thank you, Mr. Chairman.

The **CHAIRMAN**. Thank you very much, Senator Durenberger, who is a very valued member of the Pepper Commission, as well as the Finance Committee and this committee, and therefore is in a very unique role to be able to play a part in trying to fashion and shape an approach to this problem, which is of such central importance to every family in this country.

We want to welcome Senator Rockefeller, the Chairman of the Pepper Commission. During the period of just over a year, I don't think there has been any chairman of any Commission or committee that has mastered a subject so thoroughly, brought such an intense passion to the issue, and struggled so hard to find important common ground from such wide and diverse opinions as were reflected in the members of the Commission, and I thought he did an absolutely brilliant job. If this issue is moving in the Nation, as I believe it is, it is a very real tribute to his tenacity and perseverance and work and his knowledge of and commitment to it.

So we are very glad to have Senator Rockefeller, the Chairman of the Pepper Commission, before us, and it is a pleasure to be able to work with the members of the Finance Committee, Senator Rockefeller and Senator Riegle, who are leaders of the informal, joint committee, bipartisan working group. I have found the meetings to be very constructive and positive. I think what we are recognizing is that we have to address the financing and the delivery of health care. This committee just authorized $600 million for AIDS research this week. That bill is going to go through the Senate and it got a good budget mark over in the House. But if we keep moving in terms of authorizing and delivery, and we are not dealing with the financing and bringing these aspects together, we are really failing the people of this Nation, because we all know we are spending too much, too inefficiently, and too many are left out or left behind.

So we are looking forward to working very closely with members of the Finance Committee and in particular the Senator from West Virginia.

We are glad to have you here, and we look forward to your testimony.

STATEMENT OF HON. JOHN D. ROCKEFELLER, IV, A U.S. SENATOR, FROM WEST VIRGINIA, AND CHAIRMAN, THE PEPPER COMMISSION

Senator **ROCKEFELLER**. Thank you, Mr. Chairman, very much for that very encouraging and warm introduction; and Senator Durenberger, I appreciate very much your being here. If you want to ask me a question later on, I hope you will make it about that tax cap matter.

Also, I want to thank Senator Hatch who before I came in indicated that my being here was the reason that he came. I consider that very generous on his part and very genuine on his part. I also want to pay my respects to Senator Riegle who, as the chairman indicate, along with the chairman and myself and others is working on this Joint Working Group to come up with a comprehensive plan.

I will be very brief, Mr. Chairman, because the two Senators that I am talking to are members of the Commission and know this subject inside out. I won't even talk about the problem except to use the example that I constantly used during Commission meetings. It happened to have been of a young woman from Minnesota who was pregnant, and she and her husband got in their car—she was having labor pains—and went to their local hospital. They did not have health insurance, and were turned away by their local hospital and told to go 84 miles down the road to a general hospital where the delivery would be performed. But the baby was born in the car on the way, and the baby died in the car on the way. And that is something that should never happen in America. It fueled me then, and it will fuel me always. There are examples like that everywhere.

I think it is very important that we take action now. As the chairman indicated, I think we are already moving the health care subject to the center, but it is not we who are doing it; it is the problem that is doing it. And I want to just get right to our access question; I won't go into long-term care unless people want me to. I will deal with access.

We looked at alternatives. We looked, for example, at the idea of a Medicaid expansion plus subsidized private insurance, and found that what it basically did was cost a lot more—$12 billion more—and covered only half as many people. That was advanced by some of our members, and therefore we rejected that as being insufficient. It left in fact 14 million people thoroughly uncovered.

We also looked at national health insurance. There were a number of votes on the committee for national health insurance, but we rejected that as a committee on the basis that it cost $222 billion in revenues in terms of the access issue alone, as opposed to the $23 billion that we did in terms of employer-based.

So we tried to look at the options and come up with something that was moderate, that we thought could be enactable. If it is not enactable, what use is it?

So our proposal basically was to extend the job-based, employer-based system that we currently have, and the reason why—because 75 percent of workers and their dependents get their insurance from their jobs now. As a Commission, I think we felt that along with the wage, health benefits ought to come along with the job. Also, it is a fact that 75 percent of those who are not insured are working full-time and therefore they are in the job, and that therefore keeping a job-based approach to it, even though it is not a perfect one, makes the most sense, is the least disruptive, and probably the most enactable. And enactability is incredibly important.

Some of the features are that everybody contributes to the cost of the plan. The taxpayers will, employers will continue to and increasingly will continue to as others are covered, and individuals, because it was felt by all of us that everybody has to pay part of the cost because if you don't pay part of the cost, then you are probably going to overuse the health system. Really, the only ones who are excluded from part of the cost in our Pepper Commission report are those who are at 100 percent of poverty or less; everybody else has got to pay something. We think that is an important feature.

There are obviously people who aren't working; there are homeless; there are migrants. There are many who do not have health insurance and who are not working, and the question is how do we bring health access to them. We do that through a public program. Senator Hatch indicated it is a "pay or play". We think it is that with quite a difference because most of those who don't have health insurance and who are working are working for small businesses, which we define primarily as 25 or fewer employees, and we really reached out to them to try to make this program affordable. In fact, they don't have to do anything for the first five years after the enactment of this entire package if it were to be enacted, and we hope it will be. We extend tax credits to them; self-employed, unincorporated, full deductibility. We really reached long and hard to small business to make it possible for them in fact to be able to afford to buy health insurance. Ninety percent of companies that have 25 or more employees already provide health insurance. Almost 50 percent of those who have 10 or fewer employees already provide health insurance. Therefore, our assumption is that those who don't for the most part don't do so because they can't afford to. Therefore, we want to make it affordable, and we think that we do.

We worked very hard on this also by trying to reform the insurance market, trying to reach out to small business and others by reforming the insurance market. We are rather tough on that—community rates in terms of small business—and we have a minimum benefit package; it is not a Cadillac package, but it is a minimum benefit package that would have to be offered by all insurance companies and within a metropolitan statistical area, they would have to offer the same benefit package—they can offer more if they choose to, but a minimum one they must, and that is a good solid plan. And we also preempt State mandates, because that is essential in order to establish this kind of uniformity throughout.

The subsidies that we provide for small business are very generous. We say that if you want to provide health insurance, we will subsidize 40 percent through credits of your premium costs, and that lasts for a period of five years. That is a very generous thing. And those who do already who are small business 25 and below who do offer health insurance already, they also get this tax subsidy because we don't want to penalize people for doing the right thing even as we are encouraging others who are not now providing insurance to do so.

On the "pay or play" aspect of it, as I have indicated, a small business would not have to if it chose not to pay anything for the first 5 years. I don't know of any other plan that has that, and in fact, when we do say finally, after five years, that if a business has not offered health insurance, we then give them the choice of either offering health insurance or contributing to the public plan through a payroll tax. Why a payroll tax? Because a payroll tax tends to favor not a flat system, for example—it is not a flat amount, it is a payroll tax—because it tends to favor smaller business. We say on an aggregate basis $18,000 per year in a company, because we don't want to take a small law firm and let them off the hook and subsidize them that way, so we say $18,000 and below. And then I think it is a very, very equitable way to do it, but essentially, everybody at the end of five years has to be offering health insurance either by providing it or paying into a public program that then feeds into the aggregate subsidy or cost for those who do not.

We do this in stages. We want to create an atmosphere within this country within which companies can offer health insurance, people can achieve it. We Federalize Medicaid; we decided Medicaid was a disaster. In some States, the requirements are so harsh that it is almost unbelievable, so we Federalize it. We make that our mainstream public program, and we bring it at least up to Medicare rules. We start with the most vulnerable in our society—pregnant women and children. As I indicated, we get very hard after reforming private insurance. We prohibit medical underwriting. We require community rating, and a lot of other things in that respect.

On cost containment, we think we have been very aggressive. We did not do everything that could be done. "Outcomes research" is just two words, but it is also, I think, one of the basic futures and hopes for cost containment in this country. There are 7,000 medical codes, and doctors have not come together to decide what is in fact appropriate care for a certain procedure. We think this drives up the cost of medical care a great deal. Outcomes research, in which last year in physician payment reform, we attached $50 million to that for spending that will be done by physicians, and that leads to practice guidelines, which in turn leads to more appropriate standards for providing medical care across this country. We approach cost containment in a variety of other ways including, as I have already said, cost-sharing. Everybody has to pay. Everybody has to pay except if you are 100 percent of poverty or less. Liability is very important to us. We didn't write the bill because we did not have the time to, but we take ProPAC and PPRC and make them into a kind of cost containment Commission, having them look at liability, outcomes research, and a lot of other problems. But we are very serious about cost containment, and we think that it is crucial, absolutely crucial, to having this accepted.

I say that about to conclude because we are now spending $660 billion on health care in this country, and it is going to be $1.5 trillion in less than ten years at current rates of growth. On the private basis, the public basis, we cannot afford that so we decided that we had to take a moderate approach—we didn't do everything that everybody wanted; we did more than some people wanted—and essentially, we think it is an enactable program, and at least speaking as chairman, my own view is that we have got to move forward on this whole, entire comprehensive program. We cannot wait for the perfect solution. People have their ideas of "the perfect solution". If a certain piece of cost containment is not there, people say, well, we can't vote for it. We have to be prepared to move forward, and I am ready, Mr. Chairman, to work with you and Senator Riegle and Senator Durenberger and any others who want to see access to health care in this country for all of our people. It is a disgrace that we don't have it.

I thank the chairman.

[The prepared statement of Senator Rockefeller follows:]

PREPARED STATEMENT OF SENATOR ROCKEFELLER

Mr. Chairman and members of the committee, thank you for inviting me to speak to you today on the recommendations of the Pepper Commission. I appreciate your eagerness to have hearings on the recommendations on access to health care thereby beginning the process of moving toward enacting solutions. Thank you, also, Senator Riegle, for your efforts and commitment to solving the devastating problem of lack of insurance for millions of Americans.

What is the problem? Today about 32 million Americans have no health insurance, not through a private policy nor through a public program. What does it mean to go without health insurance? It means delayed care or possible denial of care for financial reasons. It means having no regular source of care. It means relying on emergency rooms for primary care. It means being sicker than people with insurance. It means that one illness could financially devastate the entire family.

Who are the uninsured? Disproportionately, they are children. About one-quarter of the uninsured are children. Three-quarters are workers and their dependents. These workers are employed primarily in small firms. Sixty-seven percent work in firms with under one hundred employees. More than half work in firms with under 25 employees. The uninsured are also disproportionately poor and near poor. Two-thirds have incomes below 200% of poverty. About three-quarters of these are in families of workers.

How are people covered in our current system? Most people are covered through a job. Seventy-four percent of workers and their dependents are covered through a job. The larger the firm, the more likely insurance is offered. Virtually all employers of 500 or more employs offer coverage. Of firms with under 10 employees, 46% offer coverage. Medicaid is intended to cover the poor who do not have insurance through a job, however, because of the restrictions on eligibility imposed both by federal law and states' choices, only 43% of the under 65 population whose income is under the federal poverty level are covered.

Why did the Pepper Commission decide on recommending a job-based public program? A number of alternative approaches were considered and rejected. We considered recommending replacing our current system with a national government run system. This approach was rejected by a majority of the Commissioners because it would be too disruptive to the country to disband the employer-based system which currently provides satisfactory coverage for the vast majority of Americans. Also, a government run insurance program would require sufficient taxes to raise the $222 billion necessary to fund the program. The Commissioners felt that the American public would not support taxes of that magnitude.

Another alternative that was rejected was a plan to expand Medicaid and provide subsidies for the near poor to enable them to purchase private insurance. This scheme was rejected because it is not cost effective and does not assure coverage for all Americans. The cost of this proposal would be $36 billion and over 14 million Americans would remain uncovered.

The Pepper Commission recommendations recognize that the a job-based approach is the best approach because a majority of Americans already get insurance through their jobs and because a majority of the uninsured are workers and their dependents. By extending coverage through the work place, we build in the most sensible and least disruptive way toward our goal of universal coverage. At the same time, we recommend creating a public program that would replace Medicaid to cover those who are not working and would also be available to employer as a way to cover their workers. This plan costs about $23 billion.

Our approach, then, is not simply to create a safety net, to paper over the cracks in our current system or to scrap our current system entirely and start from scratch. Instead, we propose to extend and repair the system we now have and build it into a system that provides universal protection to all our citizens. Some have called this a "uniquely American" approach to universal coverage. I call it an enactable approach.

What are the major features of the Pepper Commission proposal? First, we acknowledge that everyone has to pay part of the cost of insurance. No one group is asked to bear the entire burden. Employers, individuals and governments are asked to contribute a fair share.

The plan creates a federal public program that covers all nonworkers and allows employers to participate by paying a percent of their payroll on behalf of their employees. This public program replaces Medicaid for the minimum benefit package. Medicaid remains for services that are not covered by the new public plan. Subsidies for the poor and near poor are included.

Employers are assisted by reform of the private insurance market. For example, insurance companies will no longer exclude individuals or companies from plans because someone has a "pre-existing condition" that may require medical care. Also, rates for the insurance coverage will be modified to assure that firms with sick employees are not discriminated against. Another feature of reform is that in exchange for eliminating state mandates on services, all insurance companies will be required to offer a minimum benefit package which includes primary care, hospital care and preventive care services.

Small businesses are helped in a variety of ways. In addition to the insurance market reform which should make insurance more affordable and accessible, certain small businesses will be eligible for subsidies to help them purchase private insurance.

Employers are expected to do their part in solving the insurance problem. We require large businesses to either buy private insurance for their workers and their families or contribute to their coverage through the public plan. And if small employers don't voluntarily buy in the improved marketplace, they too will eventually be required to buy or contribute. When our plan is fully implemented, every American will enjoy health care coverage.

Our recommendations also take steps to control costs and assure that the care we get is of high quality. We make insurance affordable and virtually putt an end to cost-shifting -- both from the uninsured to the insured, and from businesses which do not provide insurance to businesses that do. We get better value for our health care dollar by promoting outcomes research, practice standards, and malpractice reform-- promoting high quality as well as reasonable costs. In addition, we seek to build upon the evolving efforts in government and the private sector to contain costs. For example, the Medicare payment rules would be extended to the new public program, and "managed care" would be made available to small employers. To assure that these efforts are adequate, we call on the congressional provider payment commissions, to evaluate cost experience under the program and make recommendations for further measures, as necessary.

We also acknowledge that, in addition to financing reforms, changes in the delivery of services are necessary to assure that people in medically underserved areas have accessable care. For example, we recommend that government should promote an appropriate mix of facilities and personnel through mechanisms including appropriate provider payments and special initiatives that attract providers to underserved areas.

Mr. Chairman and Members of the Committee, as I have already indicated, I believe that what I have presented to you here today is a reasoned and workable approach toward creating a universal health plan. But I'll be straight with you. Since we released these recommendations we've caught a lot of flack because our plan does not reflect any number of other proposals to reform our health care system.

I'll be the first to admit that what we propose is not everybody's notion of the ideal solution. But in my view, too often in the past, we have sacrificed the good in health care reform for the sake of the perfect. People have become so wedded to their own first choice approaches that when presented with proposals which take a different course, their second choice is to do nothing.

This stalemate has gone on too long. As a nation, the time for us to join the rest of the industrialized nations of the world for us to provide basic health protection to all our citizens has long since passed. It is time for us to release the uninsured and under-insured Americans who have been held hostage by this ivory tower debate. I hope you will join with me in making that happen. With your assistance and expertise, I know we can refine these proposals into legislation and enact them into law. We have kept the American people waiting long enough. It's time to begin.

The **Chairman**. Thank you very much, Senator Rockefeller.

I think you have given an excellent summation.

One of the criticisms that was made of the Commission was that it failed to come up with the revenues. I am interested in hearing your response to that before I give mine.

There are those who say that the Commission, by failing to address the issue of revenues, is just giving a set of recommendations without really facing the tough issues of revenues and therefore it is not a serious effort to come to grips with the problem.

Senator **Rockefeller**. Well, we did not name taxes, and I think had we named taxes we would have come into exactly the same criticism as if we had not named taxes. In other words, we could have said, well, we'll do this as a percentage of income or a value-added tax, and then all of the attention would have gone on to what it was that we did suggest.

In fact, we did suggest a great deal. We did list the cost of what everything would be—$66 billion—that had never been done before—and we also established principles, and I made the Commission vote on it, both on access and on long-term care. We bonded ourselves to the proposition that we were going to have to come up with the money; we are not sure how much will be available through the peace dividend, but we know that there is going to be a certain amount that will be.

We established three principles, and frankly, I'm glad you asked the question because I am very tired of having Donald Trump mentioned in connection with this plan. We established progressivity—any tax had to be progressive. That was voted on by all the members of the Commission. It was agreed that it had to affect all ages. It couldn't affect one age. And we agreed that it had to be a tax that grew fast enough so that we did not have to come back every year asking for new taxes. And when you really start going through that, you only end up with about four to six taxes that you are talking about anyway.

And on the subject of Donald Trump, saying, well, Donald Trump on long-term care—if I could shift subjects here for a moment—could get nursing home coverage through a nonmeans-tested social insurance program, indeed he could, but indeed, under progressive taxing, we want him to be able to get that because he is going to be taxed one heck of a lot more for that program than people who cannot afford to pay. So that in a sense the wealthy, through progressive taxation, would be helping to subsidize those who are less fortunate.

So we think we bit the bullet, and Congress and the President, when they decide what it is they want to do, we show ourselves to be pretty good at raising taxes. I think the public would be willing to point that out. And I think the important thing is to decide what it is that we want to raise taxes for, and the Pepper Commission did that and listed the cost of every element therein, and I think we met our mandate well.

The **Chairman**. Well, I must agree with you. As I understood, the mandate for the Commission was to set health policy. We weren't trying to substitute ourselves for the Ways and Means Committee or the Finance Committee in terms of financing—although as you outlined, and as will be clear to anyone who reads the report, there is a menu of different ways suggested as to how we might finance the recommendations. But as I understood, we were members of the Commission because of our interest in forming and shaping health policy both in terms of access and in terms of long-term care. We were also conscious of what the costs were going to be, but I thought that the criticism that was placed on that demonstrated a classic misunderstanding of why the Commission was established and why Senator Pepper wanted it established.

If you look at what we are expending in health care in the country versus the amounts that are recommended by the Commission, we are talking 2 to 5 percent in additional expenditures. As you point out, what we are going to be spending over the course of the next 25 years, unless we come to grips with this, is much more dramatic than what is being recommended by the Commission; the costs have to be put into some proportion, it seems to me, to be relevant. I know it is fashionable just to listen to the costs of it, but we have seen a willingness to come to grips with the health care crisis in this country as a first order of priority.

We welcome Senator Riegle here, who is the chairman of the Banking Committee. We were quite prepared to deal with the issues on the savings and loans, and those are tough issues, but what we are basically attempting to do in these hearings is to see if we can't deal with something that affects every family—every family—in the country.

On the issue of cost containment, you might mention one or two of the other things that you supported and perhaps were not accepted by the Commission, in terms of the single payer. We did not accept these recommendations, but it seems to me that there are a number of different ways, if we are going to be serious about coming to grips with this, that we ought to be thinking about—like trying to get the insurance companies to use their energy to compete by keeping costs down rather than excluding high risks. Maybe you could expand on that, because you talked about reform of the insurance companies and community rating.

Do you not agree with me that the insurance companies now are basically using all their energy to find the healthiest population to insure so that they can try and make a profit on that and leave the others behind, rather than using their energies, if you have community rating, to bring the efficiencies of creative American entrepreneurship into holding the costs down?

Senator ROCKEFELLER. Very much so. And Mr. Chairman, I think this is the year, the sooner the better, to strike in terms of insurance reform, because quite frankly I think they are more ready—the Health Insurance Association of America, Carl Schramm, with whom I have spent endless hours, Blue Cross/Blue Shield—I think they know that reforms are coming, that constraints are coming. Community rating was the way the Blues used to be. They started out that way. The risk was spread, and then as insurance companies began to compete, they began to go for the young and the healthy, and then this mad rush toward getting away from shared risk.

In fact, I think that they will be coming forth themselves with some suggestions, changing their own habits this year, and if they don't, then I think it is up to us to do so, because obviously, premiums are incredibly important, and for small business particularly, if you expect that we want them to buy health insurance, they've got to be able to afford it, and the cost of the premium for the insurance is a very basic part of that.

Mr. Chairman, if I could go back to the point on tax cap, that was an idea that was suggested and was discussed at some length in the Commission, and the idea was to put it at $250, and anything over $250 would be taxable. And people said, well, we have to have that. And the New York Times devoted an entire editorial to the fact that since this plan did not have a tax cap, therefore the Pepper Commission had wasted an entire year—an extraordinary kind of broad-minded thinking, I thought.

The point, really, on tax cap is that through a whole variety of circumstances, management and labor have been coming to understand very clearly that we cannot have first-dollar coverage. And if you look at the statistics, ten years ago 15 percent of American workers had first-dollar coverage; this year, it is 5 percent, and going down. So in other words, you base an entire approach on 5 percent of the population. Also, a tax cap does not necessarily mean that—you know, you could be favoring wealthy workers, people who are getting very high wages, in a tax cap approach. One of the problems is that you don't want to penalize those plans that might have older workers or sicker workers.

So a tax cap is certainly an idea for cost containment, but I think people should understand that managed care is being pushed by business, is being pushed by labor, and first-dollar coverage is diminishing month-by-month in this country.

The **Chairman**. Just a final question. There are 37 million who are not covered and another 60 million who have inadequate coverage, and as I mentioned in the opening statement, anyone in America is a day or a few days away from losing their job and losing their health insurance. What is your response to those who say that we need to get all these cost control measures in place before we add more coverage?

Senator **Rockefeller**. Mr. Chairman, that is probably the most fundamental public policy question that could be asked about our work, and we discussed it, as the chairman knows, at length.

There were those who wanted to do that, who said let's get all the insurance reform and all the liability out of the way, get that all placed in law and do all the cost containment, and then we will start bringing people into either private or public plans. And we rejected that just roundly for precisely the reason that you cannot hold people hostage—pregnant women and children, for example—you cannot hold people hostage until you have perfect cost containment. And we decided that we had to go at both crises at once, cost containment and making access available as well as long-term care. So that the idea of holding hostage 37 million Americans, 8 million children, who have no health insurance until you have the perfect world struck us uncomfortably.

The **Chairman**. We have been joined by Senator Riegle, who is a member of the Finance Committee and chairman of the Subcommittee on Health for Families and the Uninsured, and has been coordinating our joint task force group. We welcome him to the committee, and we hope he will participate as fully and as completely as other members of the committee. We have had good statements from both Senator Hatch and Senator Durenberger, who were here earlier, and we have now been joined by Senator Adams as well.

I will recognize Senator Adams and then Senator Riegle for their statements.

Senator ADAMS. Mr. Chairman, I just want to thank Senator Rockefeller for his statement. We have many days discussed this problem of the coverage of the 37 million. I think the recommendations that you have suggested do have great merit. I am concerned about the financing mechanism, and several of us have suggested various forms of public plans and pools within regional areas because of the different regions with the area and pools of insurance coverage. Unfortunately during our hearings, Mr. Chairman, I think it was almost universal that we did not get a response that said that anybody was going to pool and step up to do this.

I am hopeful at some point that some of the witnesses will cover some aspects of the other industrialized countries, particularly the European and German systems, which provide a more basic care for children in particular and for working families and then work upward from that.

I have always been concerned that we concentrate too much on the Cadillac care, and that it sort of sifts down and never reaches the Ford level in our society.

So I congratulate you, Senator Rockefeller, for the work that you have done.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Riegle.

Senator RIEGLE. Thank you, Chairman Kennedy.

I appreciate very much having the chance to sit in this morning. You made a passing reference to the fact that as a country, we are finding the way to go in and provide the money needed in the savings and loan system. In fact we are going to have a hearing upstairs at ten o'clock where the GAO will come in and tell us that their latest estimates are that much more money will be needed. On the one hand, we seem to be able to find money for that, but not for the uninsured people in this country, and it is a terrible contradiction in policy and in priority.

If I may, Mr. Chairman, just on a personal note, I had the great privilege to serve in this committee with you here for ten years and the other members of this committee, and when I left to join the Finance Committee, it was in part to deal with the health issue where we have to write the law to get that job done, or at least a substantial part of it, and also the responsibility for Social Security and the trade issues, other things that are critical. But it is the nature of our arrangements in the Senate, of course, where we divide this work up, and it doesn't fall orderly within one committee or another. Senator Rockefeller and I serve side-by-side on the Finance Committee; we each have responsibilities for part of the health activities within the scope of the Finance Committee. But it is obvious that all of this has to be integrated into a working formulation, not just across committee lines, but across party lines.

So I think the working group of 15 Senators of both parties, including Senator Durenberger who was here earlier and others, I think gives us the opportunity as we have been working over the last several months to craft a consensus plan where part of the legislative activity will come through one committee and part will come through another committee, but that will tie together and be a coherent and sensible response to what is an urgent national problem.

And I want to say also on this occasion, Senator Kennedy, that no one in this country has worked harder than you have or longer to try to focus this issue and bring it forward and to cause action to happen. I have a profound sense of gratitude and admiration for the fact that that fight has been underway and led by you for at least two decades, and I think we are now finally getting to the point where I think things are about to happen, with the leadership of Senator Rockefeller on the Pepper Commission and others of us who are able to play a part in this, and I see the forces coming together. I see in the business community, where large and small business understand the need to move in this area. Our hospitals are being crushed all across this country. There was a story last night about the Capitol Hill Hospital here, and I have been in hospitals in urban and rural areas in my State, and they are all being crushed financially because they cannot handle the problem of uncompensated care.

And yet we have not seen a plan put forward, I might say, out of the Executive Branch. The President, to his credit, mentioned in the State of the Union Message that we ought to take a look at it—but no plan. We have to have a plan, and I think the recommendations of the Pepper Commission that have been laid out here very ably by Senator Rockefeller are part of the road map that we need to have. And I think taking that and incorporating that as we have in the working group options which we have since distributed for public comment after the completion of the work of the Pepper Commission now gives us, everybody out there, the people in this room and others who have a commitment to want to move in this area, a way for us now to fashion a plan that we can actually build a broad, strong, bipartisan consensus for.

I am determined, Senator Kennedy, to take the part of that that falls within the Subcommittee on Health for Families and the Uninsured in the Finance Committee and see that we get it done so that before more years pass, and we have more walking wounded out in our society and other more terrible consequences of a failure to respond, that we get this job done. And when that happy day arrives, I think no one will deserve more credit for having spearheaded that effort that yourself, and of course many others, including Senator Rockefeller.

So I wanted to make those comments and participate this morning up until the time that the hearing has to start upstairs that I must chair there to make it absolutely clear that whatever it takes to get this job done legislatively within the scope of our subcommittee, I am determined to do. And these issues on revenues one way or another have to be settled and solved. The issues on restructuring in terms of cost control have to be addressed and have to be solved. And when we put this plan together on a bipartisan basis and bring it forward, I think the Administration should get aboard and should work with us and should help us to get it done, and I hope they will. I hope the pressure will be such, constructive in nature, that they will want to become partners in that effort as well because it has to be done—and not a decade from now or five years from now—it has to be done, and the time to do it is now.

So I am hopeful that we can move ahead in that way, and I thank you for the chance to speak.

I would just say one other thing and that is, as a follow-on to this effort today, on the 18th of this month, our subcommittee will be holding a hearing, and we are going to be inviting in, Senator Kennedy, some of the Governors who have been the most innovative because they have had to act because the Federal Government has been unwilling to act sufficiently. So in your State and in mine, the Governors have taken initiatives, as well as in other States. So we will be having Governors in from both parties, the HCFA administration, big business, small business, to dovetail into the work and the hearings that are happening today.

So I think we are making good progress, and very importantly, are behind the leadership that you have shown for such a long period of time.

The **CHAIRMAN**. Well, I want to thank you, Senator Riegle.

As we mentioned at the start of the hearing, we just authorized $600 million this week for AIDS, a targeted area, and we can continue to provide funds for these areas, but what we have learned over time is that you have to bring these measures together if you are going to be effective in leveraging the delivery of health care through the financing. The delivery and financing of health care have to be brought together, and that is something, Senator Rockefeller knows, on the payment reforms that were made this year, is enormously important.

I would ask Senator Riegle, Senator Adams and Senator Rockefeller if we haven't got enough studies. We've had the bipartisan Presidential Commissions that have made reports, we've got the Pepper Commission that has done work in extraordinary detail, spelling out the various alternatives. And Senator Rockefeller this morning could have spent a great deal more time talking about the different alternative proposals. We heard what I would consider the whole range of proposals; the whole range was discussed, debated, considered, and in all instances voted on in one form or another. Maybe somebody else has a proposal, but I think we have heard the range of different kinds of alternatives, because we had a broad spectrum in terms of those who were participating.

I certainly hope that the President's statement asking Secretary Sullivan to review this issue isn't going to be re-creating the wheel. I would ask Senator Rockefeller and Senator Riegle to comment briefly on whether you would agree that the basic materials, the considerations and the positions of various groups are available for policymakers to make an informed, balanced and intelligent judgment?

Senator **ROCKEFELLER**. I totally agree, Mr. Chairman. We have the Steelman, the Quad Commission Report coming up, and then we have Secretary Sullivan's report, his working group, coming up, and that will be the 30th and 31st reports on all of this, and the Pepper Commission has laid out a plan which we think is enactable and doable and affordable. I don't think we can afford not to do it, and I think we have all agreed that the time for talk has passed, and the time for doing something about this crisis is here. I think it is the major financial domestic crisis we have in this country for the next 15 years, and we can either postpone it and observe it, comment on it, or do something to solve it.

Senator RIEGLE. Mr. Chairman, if I could respond as well to your invitation, in my State, I have one million people today in Michigan without a penny of health insurance, 300,000 of which are children. To me that is really a crime. It is a crime against our society and against the future that we should allow that to happen.

You are right—there has been plenty of study. I think there has been enough study. I think it is time to craft the bill. That is what the working group is now in the process of doing. And more than crafting the bill, it is time to enact it, and that means to get it written and get it enacted here in the Congress and send it down to the President and get his signature on that bill and get this health insurance coverage out there.

We need a healthy Nation, and this is the only way we are going to have one.

The CHAIRMAN. Senator Adams.

Senator ADAMS. Mr. Chairman, I want to thank Senator Rockefeller, but one of the reasons that I am here this morning is that I had a very bad experience last week with Secretary Sullivan and with Mr. Sununu in attempting to put through the Family Independence Program in the State of Washington, which is similar to what they have in Massachusetts, which was simply to substitute a program for AFDC-type families where they would have health insurance, and they would have the ability to keep this during a period of time while they got their first job and also while they were in training.

I think the Secretary was persuaded, but we hear now that that is in jeopardy. The State is putting up money, and I hope when the Governors come in, you will quiz them in depth about this, because they are going to cut off the money, they say, for helping with this program. And it has been shown to be essential that a mother will not leave her family and her children even though she suffers on welfare to stand for a job unless she has health insurance.

So I commend you for moving toward covering this total package. And I am here this morning I guess out of a sense of outrage, Mr. Chairman, that as we have tried to do this, you are absolutely right, it has got to be comprehensive, and it has got to be all pulled together, because every time we try a special program they find some way of saying that we either can't afford it or it is costing too much. In this case it is costing a little more because people are going into the program for the first time, and they are finding that it works, and we are moving people out of the poverty level. But if we cut off their basic means of support which is as much as anything their health protection, Mr. Chairman, they will not stay on a program of work.

So I just appreciate what you have done, and we will follow your leadership down through this "valley of death" one more time.

The CHAIRMAN. One feature I like about the British system of government is when they appoint a Commission, the Prime Minister has either 60 or 90 days to get their recommendation, and the recommendations are then considered by the Parliament. In this country, as a former chairman of the Administrative Practices Committee, we have seen what has happened to the various Commissions. Generally, they are appointed when there is an issue of national concern, and they disappear. There are exceptions—we had the Burke Marshall Commission that recommended the random selection system and the draft, and others.

But how constructive it would be if we had these recommendations out for debate before the Congress and required the Administration to take a position on this. The American public would be well-served, because I believe these Commission recommendations are solid and thoughtful, and they really help to move us down the road, which Senator Pepper would have been proud of.

I want to thank Senator Riegle for his participation. We know you have to absent yourself. We'll look forward to the hearing on April 18th.

Senator RIEGLE. Thank you, and I want to make it clear, too, that we hope that a number of members of the committee here will come over and sit in with us that day, as well as the professional staff.

The CHAIRMAN. Good.

Senator RIEGLE. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Accompanying me today is Judy Waxman, of our excellent Pepper Commission staff, and I want to thank her.

The CHAIRMAN. Thank you very much.

The witnesses in the next panel represent groups on the front line of the American health care crisis. Their members must deal every day with the tragic consequences of national failure.

Charles Duvall is the President of the American Society of Internal Medicine, and Larry Gage is President of the National Association of Public Hospitals.

We'll start with Dr. Duvall.

STATEMENTS OF DR. CHARLES P. DUVALL, PRESIDENT, AMERICAN SOCIETY OF INTERNAL MEDICINE, WASHINGTON, DC, AND LARRY GAGE, PRESIDENT, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS, WASHINGTON, DC

Dr. DUVALL. Senator Kennedy, my name is Charles P. Duvall, and as recently as 7 o'clock this morning, I have been a practicing physician here in Washington, DC, and I am President of the American Society of Internal Medicine.

ASIM applauds, again, the Pepper Commission for developing a comprehensive and realistic plan for solving one of the most pressing problems facing this country—the inability of millions of Americans to have access to affordable medical care.

Let's make no mistake about it. American has two separate and unequal health care systems, one that provides access to a basic level of health insurance protection, and one that just does not.

Most Americans are fortunate to be under a system that allows them to obtain affordable care through their employer. They can and they do obtain the latest treatments and avail themselves of the technology that is all about us. They have access to regular, comprehensive, ongoing medical care with their personal physicians, and they know that they can get good care whenever they need it, without fear of becoming impoverished.

But more than 30 million Americans receive care, if and when they are able to obtain it at all, in a completely different world. For them, there is no health insurance protection.

The **CHAIRMAN**. Excuse me, Doctor. We know that you are knowledgeable, and we'll put all the statements in the record. I have had a chance to read through your testimony, and it is a good statement, but for you and for the rest of the distinguished witnesses as well, if you would be so kind as to summarize your statement.

Dr. **DUVALL**. I am very happy to abandon my prepared remarks and to wing it with you—although this won't be a "Rocky II".

One point I would like to make from my own personal experience. Senator Rockefeller made some comments about the unfortunate incident in the taxicab. Physicians all around this country have similar problems that they encounter every day. One thing I would like to underscore is the delay in health care.

I remember a patient I cared for three years ago who was found by the police in a hotel room. He had trashed the room, he was out of his mind, he had fever and delirium. This had been going on for weeks according to his friends and colleagues. He had no health insurance. He was shunted from one emergency room to another. My own hospital took him in, 15 days of intensive care, and he died of a disease that could have been prevented.

This city has boarder babies that are now being shuttled across the city from one hospital to another because of gridlock in some of the innermost city hospitals. We have a high rate of infant mortality due to failure of well-baby care, and all the other things you know about.

Our recommendations from ASIM very closely parallel those of the Pepper Commission, and we have looked at all of the issues, we think, just like the Commission and have conveyed to you a copy of our white paper on that subject.

We do not feel that a single payer plan is the way to go. We would definitely support your own ideas of following through with providing insurance through the employers. That will cover the bulk of people who are currently uninsured.

Like Senator Rockefeller, we feel that substantive reforms in the insurance industry are required. I sit as chairman of the local Blue Cross/Shield board in my spare time, and I know just how much we are getting beaten up in the marketplace because of skimming of insurance risk and the lack of community rating.

ASIM has joined with 21 other medical organizations in a coalition to press for enactment this year of comprehensive access legislation. I think that tells you something right there—that doctors in these organizations are behind this particular proposal. We know that the proposals that have been outlined by the Commission will cost money and we agree with the contention that the phrase, "Wait a minute," which I heard repeatedly on Tuesday by a high Administration official, to study the problem further, is anachronistic. I agree with you, Senator, that the number of studies that are here are sufficient to move ahead.

We would commend you, Senator Kennedy, and the Labor/Finance Working Group on Access, and Senator Rockefeller and his Commission for all the work that they have done.

Physicians stand ready to do everything we can to back such legislation and to get it enacted without further delay, and we call on business, labor, consumers and hospitals, and last but not least, the Administration, to effect this.

The statement of 37 million Americans being held hostage is something I would subscribe to. So even more important than asking my patients whether they want this done now, you ask some of those 37 million, and they will tell you the same thing. They want action, not next year or the year after. They need it now, in this Congress. And I would say let's vote.

The CHAIRMAN. Good. You're my kind of guy. Thank you very much.

[The prepared statement of Dr. Duvall follows:]

PREPARED STATEMENT OF DR. CHARLES P. DUVALL

My name is Charles P. Duvall, MD. I am an internist in private practice in Washington, D.C. and President of the American Society of Internal Medicine (ASIM).

ASIM applauds the Pepper Commission for developing a comprehensive and realistic plan for solving one of the most pressing problems facing this country: the inability of millions of Americans to have access to affordable medical care.

Let's make no mistake about it. America has two separate and unequal heath care systems, one that provides access to a basic level of health insurance protection—and one that does not. Most Americans are fortunate to be under a system that allows them to obtain affordable health insurance through their employer. They can and do obtain the latest treatments and technology. They have access to regular, comprehensive medical care through their own personal physicians. And they know that they can get good care, when they need it, without fear of becoming impoverished.

But more than 30 million Americans receive care, if and when they are able to obtain it at all, in a completely different world. For them, there is no health insurance protection. A major illness can mean personal bankruptcy. Even minor illnesses can represent an intolerably high expense. Delays in obtaining care are common and preventive care is virtually unknown. And, when they do get so sick that they can no longer go without professional care, treatment usually comes from chronically underfunded public clinics or hospital emergency rooms—or from physicians who donate their services on a charity basis.

Many other Americans—the underinsured—have insurance coverage that provides inadequate protection against the costs of a catastrophic illness. Even those Americans with good health insurance are at risk of joining the ranks of the uninsured. Unemployment or an illness followed by a change in jobs can lead to loss of coverage.

So even though most of my own patients have good health insurance protection, I know that they too must live with the fear and uncertainty of perhaps someday joining the ranks of the uninsured. And for those of my patients without health insurance, lack of coverage translates directly into unnecessary pain, suffering, and premature death.

The case of a patient of mine who recently died of AIDs illustrates the problem. This young man had been a patient of mine on and off since 1972. As a mountain climber and writer, his coverage was also off and on. In April, 1987 he was found in a local Holiday Inn with fever, headache, depression and inevitable derangement that had been coming on for some time. A local hospital emergency room was quick to ask if I would like him transferred to my hospital. Georgetown University Hospital readily accepted him based on my long-standing relationship with the patient. He died 15 days later of AIDs with huge toxicity and a brain abscess. Early diagnosis and treatment could have prolonged his life and relieved his suffering. But for this patient, it was too late. I now wonder how many other patients also stay away, because fear of impoverishment leads them to delay obtaining care.

Talk to any physician in this city, and you'll hear similar stories. In the capital of the richest country on earth, we have hundreds of boarder babies who depend on the charity of hospitals for their care and nurturing. We have children who don't survive infancy because of a lack of pre-natal and well-baby care. We have people whose only contact with a physician is when they end up in the emergency room of D.C. General Hospital.

And judging from what I hear from ASIM members nationwide, we are not alone. No part of this country has escaped the problem of inadequate access to heath insurance protection.

ASIM believes that it is time to put an end to separate and unequal health care. We have provided the committee with advance copies of a comprehensive plan to be released next week that, if enacted into law, would provide all Americans with equal access to adequate health insurance protection.

Our recommendations closely parallel the approach put forth in the Pepper Commission report and in legislation reported out of this committee last year. ASIM supports requiring all employers to provide health insurance to their employees. We advocate reforming the insurance marketplace to reduce premium costs, avoid skimming, spread the cost burden more equitably, and eliminate existing barriers to coverage. We believe that federal subsidies and tax breaks should be provided to small businesses. We believe that Medicaid should be converted from a local welfare program to one that provides adequate, consistent coverage to any American, regardless of income or locale, who cannot obtain coverage through an employer. Insurance reforms, development of practice guidelines, reductions in the administrative costs of insurance, medical liability reform, and adequate levels of patient cost-sharing should be instituted to reduce the costs of care. ASIM also supports legislation to encourage the availability of private long-term care insurance and creation of a new federal benefit to help pay the expenses of long-term care.

Expanding access to care unquestionably will cost money. But the human and economic costs of not addressing the problem are far greater. I am greatly troubled by those who say that we can't afford it, or that we should "wait a minute" and study the problem further, or that reform is okay, as long as someone else pays.

We know what the solutions are. We know that a combination of expanding employer-based health insurance and providing adequate public funding will work. We also know that if enough people want change, this country has the resources to make that change possible. And we know that the cost burden can be shared equitably, so that no one segment of society is asked to pay the entire bill.

We commend Chairman Kennedy, the other members of the Pepper Commission, and the Labor-Finance working group on access for your leadership in putting realistic solutions before the Congress. But the time has come for Congress to move forward and enact comprehensive legislation. Several weeks ago, ASIM and 21 other medical organizations formed a coalition to press for enactment this year of comprehensive access legislation, based on principles that are consistent with the Pepper Commission plan. Physicians stand ready to do everything we can to get such legislation enacted without further delay. We call on business, labor, the administration, hospitals, and consumers to do the same.

Millions of uninsured Americans are effectively being held hostage while those of us in Washington argue over whether now is the time to act. But the answer is simple. Ask my patients. Even more importantly, ask those who never get to see me because they lack health insurance coverage and are too proud to ask for charity. They'll all tell us the same thing. They want action—not next year or the year after, but now.

SUMMARY

ASIM Policies for Ending Separate and Unequal Health Care

EXPANDING EMPLOYER-BASED HEALTH INSURANCE

1. Require employers to offer employees a basic package of health insurance benefits.
2. Provide special assistance to small businesses to make the cost of offering health insurance more affordable:
   - Allow for an appropriate phase-in of the requirement;
   - Designate regional insurers and establish risk pools;
   - Allow businesses to substitute an "actuarially equivalent" plan for the required standard benefit package;
   - Provide a federal subsidy in hardship cases;
   - Preempt state laws that mandate minimum benefits; and
   - Permit full tax deductions for the costs of health insurance premiums.
3. Reform the market for health insurance by prohibiting experience rating and pre-existing condition exclusions and by establishing special rules for marketing to small groups. Once market reforms are implemented, along with expansion of Medicaid and a mandate that employers provide health insurance coverage to their employees, all individuals should be required to offer evidence of having obtained insurance coverage.
4. Provide tax incentives for individuals to set aside funds to pay for health expenses in order to supplement financing from employer-based health insurance and public programs.

IMPROVING AND EXPANDING PUBLIC FINANCING

1. Convert Medicaid from a welfare program to a source of funding for all individuals, regardless of income, who are unable to obtain employer-based health insurance:
   - Mandate national uniform eligibility standards;
   - Require individuals with incomes above the poverty level to contribute to the cost of coverage (through premiums, deductibles, and copayments) under the public plan, with the level contribution and cost-sharing varying on a sliding scale based on income.

   (As an alternative to revamping Medicaid, a new federal-state program could be established to accomplish the same purposes.)
2. Mandate a defined set of basic benefits for the Medicaid program.
3. Reform physician payment under the Medicaid program to ensure adequate incentives for physician participation and to introduce proper incentives into the system.
4. Increase federal government funding for the expanded Medicaid program to reduce the financial burden on the states.

PROVIDING COVERAGE FOR LONG-TERM CARE

1. Encourage the availability of private long-term care insurance:
   - Apply the same tax status to long-term care products as now exists for accidental death and dismemberment insurance and health insurance;
   - Allow the deductibility of insurance reserves and related investment earnings and permit the inclusion of long-term care coverage in cafeteria plans;
   - Offer tax credits for the purchase of long-term care coverage; and
   - Eliminate restrictions on the prefunding of retiree health benefits and long-term care insurance.

2. Provide a sliding subsidy to enable low-income beneficiaries (e.g., those with incomes up to twice the poverty level) to purchase private long-term care insurance.

3. Provide for federal and state regulations that enhance consumer protections in the long-term care market. These regulations should:
   - Assure appropriate standards of coverage;
   - Promote establishment of guidelines for proper disclosure;
   - Provide protections against sales abuses;
   - Regulate renewal and cancellation;
   - Assure requirements for sufficient reserves; and
   - Develop benefit/premium ratios.

4. Provide an asset protection program for individuals who purchase long-term care policies as an incentive to purchase private long-term care insurance.

5. Establish a new Medicare benefit to assist individuals in paying for long-term care. The program should:
   - Provide for adequate cost sharing by individuals;
   - Protect against depleting personal assets; and
   - Have premium contributions on a sliding-scale basis.

HEALTH CARE COSTS AND OTHER BARRIERS TO ACCESS

1. In order to assure that money spent on medical care is spent wisely and effectively, the medical profession, with the cooperation of government and other payers, should:
   - Place high priority on studying the outcomes of different medical interventions and
   - Develop practice guidelines to modify physician behavior and provide a basis for setting payment criteria.

2. Eliminate administrative hassles that impede access to care.

3. Institute reforms in the medical liability system.

4. Require some level of patient cost-sharing in all insurance plans.

INTRODUCTION

Achieving Equal Access To Health Care

America has two separate and unequal health care systems—one that provides access to a basic level of health insurance coverage and one that does not. It is time to provide *all* Americans with equal access to adequate health insurance protection.

Most Americans are fortunate to be under a system that allows them to obtain affordable health insurance through their employer. By providing access to insurance coverage, and by sharing the cost between the employer and the employee, the employer-based system of health insurance coverage provides most Americans with protection from the catastrophic costs of major illnesses. They are able to obtain the latest treatments and technology without fear of impoverishment. They are able to choose their own physicians and hospitals. They have access to regular, comprehensive medical care. The system is not perfect, but employer-based health insurance accomplishes its major purpose: assuring that no American need delay seeking care because of fear of financial catastrophe.

But there is a sizable minority of Americans—estimates range between 30 million and 37 million, or about 15 percent of the population[1]—that receives its care (if able to obtain it at all) in a completely different world. For them, there is no health insurance protection. A major illness can mean personal bankruptcy. Even minor illnesses can represent an intolerably high expense. Delays in obtaining care are common. Access to preventive care is virtually unknown. And, when they do get so sick that they need professional care, that care usually comes from chronically underfunded public clinics or hospital emergency rooms—or from physicians who donated some $6 billion in charitable care in 1989.[2]

Others have health insurance—but it is inadequate for the task. Lack of coverage for the catastrophic illnesses expenses and inadequate benefits for preventive and primary care services place too many Americans—the underinsured—at risk. Americans who have coverage under welfare-type public programs, such as Medicaid, find that chronic underfunding of those programs creates insurmountable barriers to care. As many as 20 million Americans have inadequate health insurance coverage.[3]

Even those Americans who now receive comprehensive coverage through their employer are at risk. Unemployment can lead to loss of coverage. An illness followed by a change in jobs can make it impossible to obtain coverage for that illness, since most insurers refuse to provide coverage for "pre-existing" health problems. As the cost of providing insurance escalates, more and more businesses are contemplating dropping or limiting their health benefits. Even those fortunate to have good comprehensive insurance through their jobs still live with the fear and uncertainty of joining the ranks of the uninsured.

The American Society of Internal Medicine (ASIM), representing physicians nationwide who are specialists in adult medical care, believes that we can no longer accept two separate and unequal health care systems. A comprehensive solution that gives *all* Americans equal access to a basic level of health insurance is within our grasp. Such a solution should preserve the strengths of our present system while closing its gaps; spread the burden of financing care equitably throughout society; and ask businesses, government, patients and physicians to all do their share.

This paper outlines ASIM's proposal for putting an end to separate and unequal access to basic medical care. Since any realistic solution must be based on an understanding of why some Americans do not have access to the same type of protection available to most of their neighbors, this paper begins by looking at who are the uninsured and underinsured. It then presents a series of recommendations for comprehensive long-term reform, including a comparison of ASIM's recommendations with other proposals, such as the U.S. Bipartisan Commission on Comprehensive Health Care (better known as the Pepper Commission) report and the Basic Health Benefits for All Americans Act, and an assessment of each recommendation's impact on cost and access.

Who Are the Uninsured and Underinsured?

Several recent studies have looked at the characteristics of those who constitute the ranks of the insured and underinsured, and how they differ from other Americans. Several findings are especially important in crafting a workable solution:

- **Most of the uninsured—80 percent of those Americans without health insurance—have jobs or are dependents of those who work.**[4] In fact, 14 percent of American workers have no health insurance.[5]
- **By comparison, a large majority of Americans are insured through their places of employment.** Only a small minority of Americans under the age of 65 are covered through publicly funded programs. According to the Congressional Research Service, 64.8 percent of all Americans under the age of 65 are insured through the workplace, 17.7 percent are insured through individually purchased insurance or through publicly funded programs, and 17.5 percent are uninsured.[6] Experts estimate that 85 percent of all workers and their families receive job-based health insurance.[7]
- **Of the uninsured who are the primary source of financial support for their families, 60 percent work full-time.**[8]
- **Many, but not all, of the uninsured are poor.** One third have annual incomes that fall under the U.S. poverty level ($10,989 for a family of four and $5,469 for an individual); 19 percent have incomes that fall between 100-150 percent of the poverty level; 14 percent have incomes that fall between 150-200 percent of the poverty level; and one third have incomes that are at least twice the U.S. poverty level.[9] Still, low-wage earners are as likely to be uninsured as unemployed individuals.[10]
- **Most of the working uninsured are employed by small businesses.** One-third of the uninsured are employed by businesses with fewer than 10 employees and another 25 percent are employed by firms employing between 10 to 100 people.[11]
- **Still, most businesses—including most small businesses—offer coverage to their employees.** Nine out of 10 businesses with more than 25 employees already cover their workers. Almost half (46 percent) of the smallest businesses—those with fewer than 10 employees—offered health insurance to their employees. Almost 80 percent of firms employing between 10 and 24 workers provided health insurance to their workers.[12]
- **Medicaid, ostensibly the major source of coverage for the poor, actually finances care for only 42 percent of people whose incomes are below the U.S. poverty level.**[13] The low income eligiblity standards set by many states make it impossible for many poor Americans to qualify for the program.
- **Virtually every American lacks adequate protection for long-term care.** The extraordinary costs of intensive long-term care make most people vulnerable to financial catastrophe. Medicaid, the major source of public financing for long-term care, requires people to deplete their own resources in order to qualify. Although Congress recently enacted legislation to reduce spousal impoverishment, Medicaid still poses too great a risk to personal assets.

Directions for National Health Policy

These findings suggest several important directions that should guide national policy to end separate and unequal coverage.

First, a logical national strategy should be directed toward making it possible for uninsured workers to obtain job-based insurance. The common assumption that the typical uninsured person is unemployed and without any financial resources, or is someone who works only part-time, is a myth. Most uninsured persons are no different from their neighbors with health insurance. They work full-time or are dependents of full-time workers. The only difference is that their employers are unable or unwilling to offer health insurance.

Second, since most businesses—large and small—do a good job of offering health insurance to their employees, an effective national strategy should be directed toward the minority of businesses that do not now offer health insurance. This means asking those businesses that can afford to offer coverage, but now refuse to do so, to accept the same level of responsibility to their employees, as do most firms. It also means finding a way to make insurance premiums affordable for those small businesses that now cannot afford to provide health benefits to their employees.

Third, Medicaid needs to be restructured so that it is no longer a "welfare" program for some of the poor, but a program that can provide coverage to any person—regardless of income—who cannot obtain insurance through his or her employer.

Fourth, for the majority of Americans who now have access to health insurance, improvements in the current employer-based system—rather than a complete shift away from job-based insurance—makes sense. Such improvements should protect these individuals from underinsurance or from losing their coverage because of a change in career or employment status or the onset of illness. But it defies logic to toss out entirely a system—which works well for most Americans and can be made better with modest improvements—for a new and untried approach. The goal instead should be to bring as many Americans as possible into the employer-based system—not to replace it.

Fifth, since rising costs threaten the ability of employers and government to provide adequate funding for health benefits, it is important to institute measures that make health insurance premiums more affordable and that direct expenditures on health only toward those services that are of benefit to patients.

ASIM's specific recommendations for a national policy that reflect these directions is presented on the following pages.

ASIM PROPOSALS - I

Expanding Employer-Based Health Insurance

All employers should be required to offer to their employees a basic package of health insurance benefits.

Impact on the Problem

The most effective approach to reaching most of the uninsured is to require those businesses that do not now offer health insurance to do so, with provisions to assist small businesses and to make premiums more affordable as outlined under the following recommendations. In October 1988, the ASIM House of Delegates—representing democratically elected state leaders of internal medicine and its subspecialties—became the first medical organization to call for a mandate that employers offer health insurance coverage. The Society subsequently endorsed the Basic Health Benefits for All Americans Act, introduced by Sen. Ted Kennedy (D-Mass.) and Rep. Henry Waxman (D-Calif.). Although this bill reportedly is being revised, the original version provides a useful model of a plan that is consistent with ASIM's recommendations. However, Congress should have flexibility to consider a variety of proposed implementation strategies to achieve the goals identified in this paper.

The Basic Health Benefits Act would require all employers to offer health insurance benefits to all workers who are employed more than 17.5 hours per week. A basic package of health benefits would be mandated by the bill. The Congressional Budget Office (CBO) projects that the bill's employer mandate would result in most of the previously uninsured's having access to health insurance. According to the CBO, 23 million out of 37 million uninsured—or almost two thirds of the uninsured—would then be covered through their employer.[14]

Recently, the Pepper Commission released a comprehensive plan for assuring access that contains a similar approach for expanding job-based health insurance coverage. All businesses with more than 100 employees would be required to provide private health insurance (that included defined minimum benefits) or to contribute to a public plan for all employees and nonworking dependents. Smaller businesses also would be required to offer private insurance or to pay into a public plan, unless they voluntarily provided health insurance coverage within a specified period of time to at least 80 percent of their employees. If an insufficient number of employees of small businesses were not voluntarily covered within five years (defined as 80 percent of all workers and their dependents in firms with fewer than 25 employees), all businesses would be required to either provide insurance or pay into a public plan. The end result would be the same as the Basic Health Benefits Act: Virtually all working Americans and their dependents would have access to health insurance through their employer.

Both the Pepper Commission proposal and the Basic Health Benefits Act call for requiring employers to subsidize at least 80 percent of the cost of health insurance premiums, thus minimizing any undue economic burden on working Americans.

Cost Impact

There is no question that mandating employer-based health insurance would be effective in substantially reducing the numbers of the uninsured, and because of the specified benefits requirements, the underinsured. But some have questioned whether the cost of such a requirement is too high for many businesses.

The evidence suggests, however, that the actual net cost to most businesses is not inappropriately high. The total value of the insurance that would be purchased by businesses under the Basic Health Benefits Act is estimated to be $33 billion. The net cost would be $18 billion as a result of eliminating uncompensated charitable care costs that currently are passed on to businesses in the form of higher premiums, plus the addition of other provisions in the bill that would result in savings to businesses. The average hourly cost of an indemnity plan that meets the bill's requirements is estimated at 80 cents for a full-time worker, of which the employer would pay 64 cents. A managed care plan would cost employers 54 cents per hour. Put another way, the costs of the bill's employer mandate would represent four-tenths of 1 percent of total wages.[15] The Pepper Commission estimates the cost to employers of its requirement at $20 billion.[16]

For many businesses—those that are now providing health insurance to their employees—costs actually would be lower, since they are now indirectly subsidizing, through higher premiums, the health care expenses of their competitors' uninsured employees. All employers would benefit from the insurance reforms discussed later in this report.

And for those employers who can now well afford to provide health benefits to their employees, but who refuse to do so, the proposed mandate simply asks them to pay their fair share. Although most of the working uninsured are employed by small businesses that have a legitimate concern about costs, one-quarter of uninsured workers are employed by firms with 1,000 or more employees.[17] As noted earlier, most small businesses—including half of those with fewer than 10 employees—now provide health benefits. Those businesses would stand to gain under a more equitable sharing of costs.

Nor would the economy suffer significant damage. Several studies, which take into account jobs that will be gained in the health care sector, found no net job loss as a result of the Basic Health Benefits for Americans Act. Still other studies, which did not take into account offsetting gains, found a small increase in unemployment (one-tenth of 1 percent or less over a three-year period).[18]

Most importantly, these costs must be compared to the far greater human and economic costs of denying millions of adult Americans and their children access to health insurance.

Requiring employers to offer health insurance coverage enjoys extraordinarily broad public support. Two recent polls found that approximately three out of four Americans felt that employers should be required to provide health insurance. The same level of support was found in all regions of the country and among all political ideologies.[19] In addition to ASIM, at least 21 other medical associations have endorsed mandatory employer-provided health insurance. The American Hospital Association and a number of other organizations representing health providers, consumers and labor also have endorsed this approach as part of a comprehensive strategy to expand access. Several business leaders also have endorsed the concept.

Most of the opposition to an employer mandate have come from small businesses, which understandably are concerned about the impact of this requirement on their economic viability. However, both the proposed Basic Health Benefits Act and the Pepper Commission report include measures to assist small businesses and to reform the market for health insurance to lower premium costs.

2 **Provide special assistance to small businesses to make the cost of offering health insurance more affordable. Specifically, allow for an appropriate phase-in of the requirement, designate regional insurers and establish risk pools, allow businesses to substitute an "actuarially equivalent" plan for the required standard benefit package, provide a federal subsidy in hardship cases, preempt state laws that mandate minimum benefits, and permit full tax deductions for the costs of health insurance premiums.**

Impact on the Problem

Both the Basic Health Benefits Act and the Pepper Commission proposal recognize the potential adverse impact on some small businesses of any requirement that employers provide private health insurance to their employees. After all, the cost of such insurance is the primary reason that some small businesses are unable to offer such health benefits. The Congressional Research Service estimates that health insurance premiums for small employers average 10 to 15 percent higher than for large employers.[20]

The Basic Health Benefits Act would directly help small businesses in several ways. Many businesses that now offer good health insurance coverage would not have to upgrade their plans as long as their benefits packages are actuarially equivalent (i.e, the employer's dollar contribution to the plan is equal to what would be the case if they offered the specified benefits). New businesses with fewer than 10 employees would be required to offer only a low-cost catastrophic plan in the first two years. Full coverage of businesses with fewer than five employees would be phased in over five years.

Companion legislation would allow 100 percent tax deductibility of the cost of self-employed and unincorporated business' contribution, instead of the current 25 percent limit. All small businesses that currently insure their workers and those who would be required to start offering health insurance would benefit from a system of regional insurers. Under the regional insurance program, small businesses would be offered the economy of scale, group purchasing power, and reduced sales and administrative costs previously available only to larger businesses. The Small Business Administration reports that 17 percent of very small employers (one to nine employees), 3 percent of small employers (10 to 25 employees) and 22 percent of employers with 25 to 50 workers cite the unavailibility of group coverage as a reason for not offering health insurance.[21]

Finally, the bill provides a direct federal subsidy for small businesses that spend more than 5 percent of gross revenues on premiums. Seventy-five percent of the cost in excess of this ceiling would be paid by the federal government. A similar subsidy program has been in effect in the state of Hawaii, which has required employers to offer health insurance for the past 10 years. In those 10 years, however, only four businesses applied for a subsidy due to hardship.[22]

The Pepper Commission report provides an even more extensive program of assistance to small businesses. The employer requirement would not begin for large employers until the third year of the plan; businesses of 25 to 100 employees would not be subject to the requirement until the fourth year, and businesses with fewer than 25 employees would have five years to comply. Small businesses that voluntarily insure 80 percent of their employees would be exempt. The option of contributing to a public fund, rather than purchasing private insurance, also gives small employers greater choices in how to cover their employees, although ASIM strongly believes that the contribution to the public fund must be set at a level to encourage provision of private insurance to the greatest extent possible.

Under the Pepper Commission plan, firms with fewer than 25 employees and average payrolls below $18,000 would be eligible to receive a 40 percent tax credit/subsidy for the cost of health insurance. Employees of these firms with family incomes up to twice the poverty level would receive a subsidy.

In addition, the plan calls for the creation of a voluntary reinsurance mechanism through which insurers could spread the risk of insuring high-risk persons or groups. ASIM believes that this approach could be taken a step further, by legislatively mandating state risk pools to make coverage available at standard group rates to high-risk individuals. This would enhance the ability of small businesses to purchase coverage at a more affordable rate than might be available on the private market.

Both the Basic Health Benefits Act and the Pepper Commission would preempt state laws that require insurers to offer a specified package of minimum or basic benefits. By substituting federally determined basic benefits, employers would be protected from state governments mandating benefit expansions that drive up the costs of premiums.

Cost Impact

The Basic Health Benefits Act would save small businesses that currently provide health insurance an estimated $4.8 billion, because they would have the opportunity to participate in the regional insurance program and offer managed care programs. The regional insurance program would reduce premiums to small businesses by 10 percent as a result of savings on sales and administrative costs, and the availability of managed care options would save an additional 15 percent, for a total premium reduction of 25 percent.[23] The cost to the federal government of the subsidy program would be about $200 million in the first year but would rise to $600 million by the fourth year.[24]

Small businesses and their employees would receive annual subsidies costing the federal government $8.4 billion as proposed in the Pepper Commission report. The 100 percent tax deductibility for self-employed individuals and unincorporated firms, if it had been implemented in 1988, would have resulted in an estimated reduction in federal revenue of $500 million in 1988, $900 million in 1989, and $1.3 billion in 1990, which represents an equivalent amount of tax savings to small businesses.[25]

3 Reform the market for health insurance by prohibiting experience rating and pre-existing condition exclusions and establishing special rules for marketing to small groups. Once market reforms are implemented, along with expansion of Medicaid and a mandate that employers provide health insurance coverage to their employees, all individuals should be required to offer evidence of having obtained insurance coverage.

Impact on the Problem

Both the Pepper Commission report and the Basic Health Benefits Act attack practices in the insurance industry that now drive up costs, particularly to small businesses, and leave too many Americans at risk for losing health insurance coverage due to illness.

Prohibiting exclusions for pre-existing conditions, as both plans would do, would close one of the major gaps in our present insurance system. Currently uninsured individuals who become ill and then try to purchase insurance on their own, or who otherwise would become eligible for job-based health insurance, no longer could have benefits for their illness denied by insurers. Currently insured individuals who change jobs (and insurance plans) also could no longer be denied coverage for a pre-existing condition. The Office of Technology Assessment estimates that 20 percent of all Americans who apply for commercial health insurance face pre-existing condition limitations resulting either in increased premiums or exclusions from coverage.[26] Since prohibiting pre-existing condition exclusions could result in individuals declining to obtain health insurance until they are ill, the Pepper Commission appropriately would require all individuals to document that they have obtained coverage either through a private or public plan. Once the availability of insurance is guaranteed, no one would be permitted to simply decline to obtain coverage.

The current practice of experience rating—basing premiums on the characteristics and claims experience of the particular group being insured—drives up costs for small businesses. Small businesses can be subject to huge premium increases if only a few of their employees are viewed as "high risk," or if several of their employees take advantage of their health benefits during a particular year. The Pepper Commission proposal would outlaw the practice. Instead, insurers would set rates based on the characteristics of the entire community (community rating), meaning that all employers would have their premiums established on the same terms.

The Pepper Commission report also directly confronts many of the other barriers that small businesses must face in obtaining affordable coverage. Insurers would be required to guarantee acceptance of all groups wishing to purchase insurance. Rates could not be increased selectively for any group in a plan. Enrollment would be for a specified minimum period. Both the Pepper Commission and the Basic Health Benefits Act would require insurers to offer small businesses managed care plans if such plans are available to large employers.

Cost Impact

Replacing experience rating with community rating would substantially lower premium costs for small businesses, although precise estimates of the impact are not available.

4 Provide tax incentives for individuals to set aside funds to pay for health expenses in order to supplement financing from employer-based health insurance and public programs.

Impact on the Problem

Allowing individuals to set aside tax deductible funds each year to help pay for future health care expenses would provide an important source of supplemental financing for health care. Similar in concept to Individual Retirement Accounts (IRAs), individuals would be given an incentive to save money to help pay for their health care expenses. Interest earned on the account also would be tax free. Savings and interest income would be taxable only upon withdrawal to supplement benefits under private and public health insurance programs.

Neither the Basic Health Benefits Act nor the Pepper Commission report includes a recommendation for "Health IRAs," although the Pepper Commission calls for inclusion of long-term care policies in employer cafeteria plans, which would enable employees to set aside pretax dollars to buy long-term care insurance.

ASIM believes that "Health IRAs" should be viewed as a supplement to requiring employers to provide health benefits and expanding public programs, not as an alternative to those policies. Although some have advocated "Health IRAs" as the primary source of financing for medical care, ASIM believes that without an expansion in employer-based health insurance and substantial improvements in public programs, Health IRAs by themselves would leave too many Americans without adequate coverage. It is not clear how many Americans would choose to set aside funds to pay for future medical care expenses, even with favorable tax treatment. Moreover, low wage earners, who are more likely to be uninsured, are less likely to contribute to a Health IRA. For these reasons, ASIM advocates the inclusion of Health IRAs only as a way for some individuals to supplement coverage by insurers and the public sector.

Cost Impact

Depending on the number of individuals who take advantage of this option, some loss in federal tax revenues is likely. The Joint Tax Committee estimates that a bill by Rep. French Slaughter (R-Va.) to create Health IRAs would have resulted in loss of federal revenue in 1988 of $2.5 billion, $6.8 billion in 1989, $7.2 billion in 1990, and $7.9 billion in 1992.[27] By providing an individual source of financing for health care, however, some savings to businesses and government might be expected. Because of the potential adverse impact on federal revenues, however, ASIM believes that making federal funds available for the other recommendations in this plan of action (e.g. expansion of public programs, as described in the next section) should take priority over establishing Health IRAs. Health IRAs could be added as resources become available.

ASIM PROPOSALS – II

Improving and Expanding Public Financing

Convert Medicaid from a welfare program to a source of funding for all individuals, regardless of income, who are unable to obtain employer-based health insurance. Specifically, national uniform eligibility standards should be mandated. Individuals with incomes above the poverty level should be required to contribute to the cost of coverage (through premiums, deductibles and copayments) under the public plan, with the level of contribution and cost-sharing varying on a sliding scale based on income. As an alternative to revamping Medicaid, a new federal-state program could be established to accomplish the same purposes.

Impact on the Problem

Even with a mandate that employers provide health insurance coverage and with the insurance reforms described earlier, there will still be individuals who otherwise would be without health insurance coverage. Unemployed, self-employed and part-time (those who work less than 17.5 hours per week) individuals and their dependents could still be without access to health insurance. Without expansion of Medicaid or creation of a comparable public program to provide coverage for all of the remaining uninsured, approximately 14 million of the uninsured still would not have access to health insurance.[28]

There is widespread agreement on the need to reform the current Medicaid program or to replace it with a new one, so that public funding for medical care no longer is linked to AFDC (Aid for Families With Dependent Children) or other welfare programs. With fewer than half of all individuals below the poverty level now eligible for Medicaid, the program—as currently structured—is clearly inadequate to the task of providing coverage for the poor, let alone serving as a vehicle to provide access for uninsured individuals with incomes above the poverty level.

The Basic Health Benefits Act would correct this fundamental flaw by establishing uniform eligibility standards for Medicaid or another comparable program. The first phase of the public program (implemented simultaneously with the employer requirement) would cover all uninsured children of families whose incomes are below the poverty level and pregnant women whose incomes fall between the poverty line and 85 percent above that line. This would expand coverage to 4 million unemployed persons.[29]

The second phase of the program, which would be implemented in 1996, calls for providing coverage for all uninsured adults with incomes up to 85 percent above the poverty line. An estimated 5.7 million more Americans would now be covered.[30]

The third phase, to be implemented by the end of the decade, would cover all of the remaining uninsured.

Copayments, deductibles and premiums for nonworking individuals and dependents between the poverty line and up to 85 percent above the poverty level could be imposed, at state option. Copayments and deductibles for those with incomes beyond 85 percent above the poverty level would be equal to those required under the employer-based plan. Federal premium subsidies and limits on premiums would be mandated based on gross income. The Pepper Commission advocates a similar approach. In the first year, all uninsured pregnant women and children up to age 6 would be eligible to enroll in a new federal-state public plan that would replace Medicaid, if they are from nonworking families or in the families of workers whose employers do not provide coverage.

In the second year, the plan would be available to all uninsured children up to age 18. Costs would be subsidized, according to ability to pay, at least for those with family incomes up to double the poverty level. More individuals initially would fall under a public plan with the Pepper Commission proposal than the Basic Health Benefits Act. This is primarily because the proposed Pepper Commission expansion of the public program would take place prior to the requirement that employers provide health insurance. Also, the income eligibility standards under the commission's plan are higher (100 percent above the poverty line compared to just 85 percent above the line under the Basic Health Benefits Act) after the second year. In years three, four and five, businesses (depending on size) would be required to provide health insurance, meet voluntary coverage goals, or contribute toward the public plan to cover their employees and dependents. Within five years, all individuals would be covered either through their employer or under the public plan.

The Pepper Commission approach, by giving employers the option of providing coverage for their workers through the public program, also is likely to end up with a larger proportion of individuals insured under the public program instead of private insurance than would be the case under the Basic Health Benefits Act. As explained earlier, if Congress decides to give employers this option, ASIM believes it is essential that a sufficient monetary incentive exists to encourage employers to insure their workers through private insurance to the maximum extent possible.

Support for establishing national uniform eligibility standards for Medicaid has also come from the Health Policy Agenda for the American People (HPA) Ad Hoc Committee on Medicaid Reform, chaired by the Hon. James Tallon, majority leader of the New York State Assembly. The committee included representatives of the medical profession, insurers and consumers. The HPA recommended that eligibility for Medicaid be set at no less than the U.S. poverty level. The HPA committee recommendation assumed inclusion of all currently uninsured individuals below the poverty level in Medicaid. Since an employer mandate was outside the charge of the HPA committee, it did not address how many of these individuals could instead be covered through the workplace. Extending current Medicaid benefits to the uninsured poor would cover 10.9 million individuals.[31]

Although ASIM strongly believes that a comprehensive solution to the access problem requires expansion of Medicaid along with an employer mandate, the Society believes that the most critical need is to provide coverage for our poorest citizens. Therefore, ASIM would support enactment of the HPA recommendation to expand coverage to all individuals below the U.S. poverty level as an interim step toward a comprehensive plan involving expansion of employer-based health insurance. The Omnibus Budget Reconciliation Act of 1989 took an important step toward including all poorer Americans in Medicaid by mandating coverage for all pregnant women, infants and children in families that are 33 percent above the poverty level, with the income limit rising in future years.

Cost Impact

The federal cost of the public portion of the Basic Health Benefits Act (which includes the standardized benefits package described below) is estimated to increase from $1.7 billion in the first year to $3.5 billion in the fourth year. The final phase of the plan is estimated to cost another $1.7 billion, for a total cost of $5.2 billion annually.[32]

The federal cost of the public portion of the Pepper Commission (including the standard benefits package and improvements in provider reimbursement) is projected to be $3.4 billion in the first year, about $10.1 billion to $13.4 billion in the second year, $3.5 billion in year three, $2.8 billion in year four, and $11.8 billion in year five, for a total net federal cost of $31.8 billion. Elimination of the federal subsidy to small firms with low wage earners would save $8.4 billion in year seven, for a total net cost to the federal government of $23.4 billion annually.[33]

Expansion of current Medicaid benefits to all those below the U.S. poverty level, in the absence of an employer mandate, would cost federal and state governments $9.05 billion. Some of those costs would be offset from savings in paying for uncompensated care, with a total net cost of $7.75 billion.[34] Benefits expansions proposed by the HPA would cost considerably more than just expanding access to current benefits.

2

Mandate a defined set of basic benefits for the Medicaid program.

Impact on the Problem

The Pepper Commission, the Basic Health Benefits Act and the Health Policy Agenda report all agree on the need to improve and standardize benefits under Medicaid or a comparable new program.

The Basic Health Benefits Act would require all states to offer the same basic benefits as those mandated under private, employer-based health insurance, including medically necessary hospital care, physician care, diagnostic tests, prenatal care, well-baby care and a limited mental health benefit.

Under the Pepper Commission plan, a new federal-state program would be created to offer basic services, including hospital and surgical services, physician services, diagnostic tests, limited mental health benefits, preventive services (prenatal care, well-child care, mammograms and Pap smears, colorectal and prostate cancer screening procedures, and other preventive services that evidence shows are effective relative to cost), and early periodic screening and treatment services for children.

The HPA offers the most ambitious list of benefit expansions. In addition to the benefits proposed under the other two plans, it would include institutional care for the elderly and the disabled, dental services, family planning services, and home health and personal care services.

In order to protect those most at risk under the current system, ASIM believes that it would be appropriate to mandate expansions of Medicaid's benefit structure as an interim step toward a more comprehensive solution requiring an employer mandate.

Cost Impact

The costs of the Basic Health Benefits Act and the Pepper Commission proposed standard benefits were included in the earlier cost estimates.

The HPA benefit package, in the absence of an employer mandate, would increase Medicaid spending (federal and state) by between $6.5 billion (for a "median" package) to $21.5 billion (for a comprehensive package), in addition to the $9 billion to expand eligibility.[35] Since the HPA package is the most expensive of the proposals, it might make sense to begin with a more basic benefits package, such as proposed in the other two plans, and then augment the package further as funds become available.

3

Reform physician payment under the Medicaid program to ensure adequate incentives for physician participation and to introduce proper incentives into the system.

Impact on the Problem

Low levels of reimbursement under most state Medicaid programs have created significant barriers to access to care. Access to primary care services (internal medicine, pediatrics, family practice and obstetrics) that historically have been paid disproportionately less than other services, has been particularly impeded. Moreover, payments for services vary widely among states. Maximum payments for brief follow-up office visits ranged from $6 in New Hampshire to $28.41 in Alaska.[36]

All three of the major proposals for Medicaid reform address this inequity. The Pepper Commission would model future reimbursement under its new federal-state program on the Medicare physician payment reform legislation enacted by Congress in 1989. Beginning in 1992, Medicare will reimburse for all physician services based on a resource-based relative value scale (RBRVS), which will substantially improve payments for undervalued primary care—or evaluation and management—services. By narrowing the historic gap in compensation between evaluation and management services and surgical and technological procedures, more appropriate incentives would be introduced into the system. The Pepper Commission would also immediately manda[illegible] improvements in reimbursement for obstetrical and pediatric care.

ASIM supports the Pepper Commission proposal to base future reimbursement under Medicaid (or a comparable new program) on the Medicare RBRVS fee schedule, provided that this is clarified to state that reimbursement under the state program would be no less than would be paid under the Medicare RBRVS fee schedule for a comparable service, states would have the flexibility to further increase payments for services where particular access problems exist, and other Medicare

rules (such as volume performance standards and limits on balance billing for higher income individuals) would not be mandated.

The Basic Health Benefits Act simply requires states to offer payment rates at levels adequate to insure access. The Health Policy Agenda similarly recommends that Medicaid expansion would include policies and incentives to encourage provider participation. The HPA cites a Congressional Research Service estimate that shows raising the level of Medicaid payments to physicians would increase by 13.6 million the number of visits to physician offices, a clear indication of the importance of improved reimbursement in eliminating barriers to care.[37]

The Physician Payment Review Commission, an independent body of physicians, economists, consumers, business and health professionals established to advise Congress on reform of physician payment under Medicare, and now Medicaid, reviewed several studies on the effects of fee levels on access. The commission reports that "practically every study has reached the same conclusion: Higher Medicaid fees result in greater physician participation in the program."[38]

Cost Impact

The cost of applying the Medicare rules of payment to the Pepper Commission's proposed federal-state public program were estimated to cost $4 billion annually at full implementation.[39]

There is no specific information available on the potential costs of improved reimbursement as called for by the Basic Health Benefits Act.

The HPA estimates that if states reimbursed physicians at Medicare levels and hospitals at incurred costs, costs would rise an additional $4.4 billion to $5.5 billion, of which $1.5 billion would represent increased spending on physician services.[40] The Physician Payment Review Commission cited one study, however, that found that every 1 percent increase in fees was associated with a 0.5 percent increase in Medicaid expenditures. One of the reasons that the relationship was less than one-to-one was that there was an inverse relationship between the number of recipients of outpatient care and Medicaid fees, indicating the apparent substitutability between outpatient and office services. In other words, higher expenditures on office visits might be partially offset by fewer visits to more expensive hospital outpatient departments or emergency rooms.[41]

To reduce the financial burden on the states, increase the federal government's funding for the expanded Medicaid program.

Impact on the Problem

The HPA specifically has called for the federal government to bear a greater burden of the fiscal impact of eligibility expansion. The Pepper Commission agrees: It calls for the fully phased-in public plan to be financed and administered primarily by the federal government. States would continue to contribute the same amount that they currently spend on Medicaid to the new program. The Basic Health Benefits Act would match eligible state expenditures for the program at Medicaid matching rates, which suggests that the Act would not significantly alter the share of the costs of the program borne by federal and state governments.

ASIM believes that it is essential that the federal government pay the largest portion of the proposed Medicaid expansions. Uniform benefits and eligibility would financially strap poorer states with more limited resources. Many of the states that now have more restrictive benefits, eligibility and reimbursement simply are unable to afford program expansions. A federal mandate that all states enhance their programs to meet national guidelines makes sense only if the federal government is willing to finance largely those expansions. Opposition of the nation's governors to further federal mandates to improve Medicaid would be muted it the federal government were to provide its fair share.

Cost Estimates

The estimates of increased federal costs and savings to states depend on how large a portion of program expenditures the federal government would pick up. More detailed projections are not now available.

ASIM PROPOSALS - III

Providing Coverage for Long-Term Care

1. Encourage the availability of private long-term care insurance by: applying the same tax status to long-term care products as now exists for accidental death and dismemberment insurance and health insurance, allowing the deductibility of insurance reserves and related investment earnings, permitting the inclusion of long-term care coverage in cafeteria plans, offering tax credits for the purchase of long-term care coverage, and eliminating restrictions on the prefunding of retiree health benefits and long-term care insurance.

Impact on the Problem

Currently, the market for long-term care insurance is hindered by inequitable tax treatment. Allowing tax deductions of long-term care insurance premiums paid by employers and tax benefits for insurance companies—allowing them to accumulate interest on collected premiums—would help stimulate the long-term care insurance market place. Changes in the tax code to accomplish these purposes were proposed as part of the Long-Term Care Assistance Act, introduced in 1988 by Sen. George Mitchell (D-Maine). The bill also allowed for inclusion of long-term care policies in employer cafeteria plans, in order to enable employees to purchase these plans with pretax dollars. The proposed changes in the tax code were endorsed by the Pepper Commission as well. The Long-Term Care Assistance Act reportedly is being redrafted prior to its reintroduction.

Prefunding of long-term care insurance, through Health IRAs or other mechanisms, would help reduce the economic burden on the next generation.

Cost Impact

Little data is available on how the proposed changes in the tax code would affect the cost of long-term care insurance. One estimate suggested that premiums could be as much as 11 percent lower for insurance purchased at age 65 if long-term care insurance reserves were treated the same as life insurance reserves.[42]

The Pepper Commission estimates that $6.7 billion in lost federal revenue in fiscal 1990 would result from its proposals to change the tax code to encourage long-term care insurance.[43]

2. Provide a sliding subsidy to enable low-income beneficiaries (e.g., those with incomes up to twice the poverty level or less) to purchase private long-term care insurance.

ASIM supports a bill introduced in 1989 by Rep. Barbara Kennelly (D-Conn.) to provide federal subsidies to help low-income individuals purchase private long-term care insurance. This would extend assistance to those individuals who would not benefit from tax credits, as would middle- and upper-income groups. Although it is unclear how many lower-income Americans would take advantage of the subsidy, ASIM believes that it is important to establish the principle that individuals with lower incomes should not be excluded from the long-term care market.

Cost Impact

No data is currently available on the cost of the proposed federal subsidy to low-income persons.

3 Provide for federal and state regulations that enhance consumer protections in the long-term care market. These regulations should assure appropriate standards of coverage, the establishment of guidelines for proper disclosure, protections against sales abuses, regulation of renewal and cancellation, requirements for sufficient reserves, and development of benefit/premium ratios.

Impact on the Problem

Any proposal to stimulate the availability of long-term care insurance must protect consumers from the deceptive and fraudulent practices that all too often have accompanied marketing of Medicare supplemental insurance (or Medigap) policies. Without such protection, individuals are at risk for purchasing inadequate insurance, paying excessive premiums or purchasing duplicate coverage.

The Pepper Commission agrees with the need for states to regulate long-term care insurance by using federal or stricter standards. The commission recommends that the federal government encourage states to strengthen civil penalties for misrepresentation, sales knowingly made of duplicative insurance or sales of unapproved policies by mail.

Cost Impact

No data is available on the costs to state authorities or the insurance industry associated with promulgating and complying with stricter regulatory standards.

4 As an incentive to purchase private long-term care insurance, provide an asset protection program for individuals who purchase long-term care policies.

Impact on the Problem

Rep. Kennelly's proposal would provide a strong incentive for individuals to purchase long-term care policies as a way of protecting themselves from future impoverishment. Under her plan, an individual's assets would be protected up to the dollar value of the benefits provided by the insurance. Once the individual's unprotected assets are used, he or she would become eligible to receive long-term care benefits under the Medicaid program. For example, if an individual with $50,000 in assets purchased a long-term care policy with $50,000 in long-term care benefits, the individual would be able to maintain those assets and still qualify for Medicaid coverage after the private policy's benefits were exhausted.

Cost Impact

No estimates are available on the cost of this proposal.

5 Establish a new Medicare benefit to assist individuals in paying for long-term care. The program should provide for adequate cost sharing by individuals, protection against depleting personal assets and premium contributions on a sliding scale basis.

The Long-Term Care Assistance Act, as proposed by Sen. Mitchell in 1988, would provide for Medicare coverage of long-term care after an individual paid for the first two years of chronic nursing home care. Medicare would pay 70 percent of costs for an unlimited time in a nursing home after the first two years. Home health care benefits would be expanded to include benefits of up to $2,000 a year with a 50 percent copayment. The new benefit would enable individuals caring for a Medicare beneficiary at home to hire someone to relieve them when needed. The new benefit would be financed partly by premiums that would increase with beneficiary income.

The Pepper Commission proposes an even more ambitious plan. Rather than paying benefits after the beneficiary has financed care out-of-pocket for a defined time period, the commission would pay for the entire cost of the first three months of skilled and custodial nursing home care, except for a modest copayment. During the first three months, all income and assets would be protected. After the first three months, individuals must contribute their income toward the cost of care minus a personal needs and housing allowance. Individuals would contribute non-housing assets above $30,000 for single persons and $60,000 for married persons. The commission also proposes a separate social insurance program for home and community-based care.

ASIM believes that either approach is consistent with the principles of asset protection, cost-sharing and varying contributions by income. More debate is needed on whether or not the beneficiary should be required to pay more out-of-pocket up front, compared with having the federal government finance the first few months in a nursing home. The Pepper Commission's rationale for this proposal is that most Americans who need long-term care are in and out within three months.

Given the huge costs of financing long-term care, Congress will need to carefully consider what is a realistic level of federal support. ASIM also believes that although providing benefits for long-term care is an appropriate national objective, the highest priority must go toward providing access to care for the more than 30 million Americans without any health insurance coverage. Consequently, if limited resources dictate a choice between implementing that portion of our program calling for Medicaid expansion and an employer mandate, or that portion calling for the creation of a long-term care benefit, priority must go toward the former. Long-term care benefits could be added as funds become available.

Cost Impact

The Pepper Commission long-term care proposal is estimated to cost $42.8 billion.[44]

The Long-Term Care Assistance Act, as initially proposed in 1988, was estimated to cost between $16 billion and $18 billion.[45]

ANALYSIS

Advantages of ASIM's Access Plan Over Alternative Approaches

The common thread running through ASIM's proposals on access and long-term care is one calling for the private sector and government to share the costs of expanding access to care. We believe that the way most Americans now get coverage for medical care—through employer-based health insurance—has worked well and must be preserved, albeit with some substantial improvements. The objective must be to bring as many Americans as possible into that system—not replace it.

Some have advocated that this country move toward a single-payer system. Although the specifics of single payer proposals vary, they have one element in common: The federal and/or state governments would finance coverage for all Americans. Some of the plans would do away with private insurance. Others would have the government issue vouchers to purchase private insurance, or would contract with private insurers to administer the program. Some would administer the plan largely at the federal level; others would give primary responsibility to the states. Proponents of a single-payer system tend to look toward the Canadian system as a model.

Whatever variation of a single-payer system is proposed, however, there are significant drawbacks compared to ASIM's proposed mix of public and private funding sources. Specifically:

1. **By giving one entity—government—an exclusive monopoly over financing care, patients would be limited to receiving care only under that system.**

Under the current pluralistic system, if patients or employers do not like the service they receive from a particular insurer or feel that payments or benefits under the plan are inadequate or do not care for restrictions the plan places on access to physicians and hospitals, they can simply purchase coverage by another plan. But if the government-financed program is the only practical choice available to patients, they cannot just "fire" the government and select another plan. Only the very wealthy would have the resources to opt out entirely from the system. Even if a single-payer plan contemplates a role for private insurers, the fact that the government still pays all the bills would result in the same inherent restriction on choice. If patients do not like medicine financed and controlled by the government, simply finding another insurance plan that operates within that system does not really offer the only choice that matters: the freedom to obtain coverage through another financing source.

2. **A single-payer system would limit competition.**

It is ironic that at a time when more competition is being introduced into virtually all segments of society, proponents of a single-payer system propose to give a monopoly to a plan operated and financed by the government. Most Americans would agree that consumers benefit when government programs are forced to compete with private sector alternatives. Consumers, for example, benefit when the U.S. Postal Service is forced to compete with private delivery services. But in a far more important arena—the health of Americans—some are calling for a government monopoly. That just doesn't make sense.

3. **If the government pays the entire health care bill, the care available to individuals would be at risk to the annual budgetary battles over competing priorities.**

If the government accepts the enormous responsibility of another massive entitlement program, medical care would be at risk to competing budget priorities. Congress would need to balance funding for medical care against such other priorities as defense spending, deficit reduction, education and aid to farmers. Given that the new single-payer program would immediately become one of the largest spending programs, it would be a natural target for spending cuts to pay for other national priorities—or to reduce the deficit. Medicare, which has been cut by more than $35 billion during the past nine years, is one example of the pressure to cut costs that would be placed on the new program.

4. **A single-payer system places too much control over patient care in the hands of governmental agencies.**

After promising to pay for the health care bills of all Americans, Congress immediately would be under pressure to cut costs. This would inevitably lead to efforts to restrict benefits for needed services, to penalize financially physicians and hospitals that provide patients with the care they need and to limit access to new technology. The government also would have a reason to impose even more administrative barriers that are designed to make it difficult for physicians to order and patients to obtain benefits for needed services. As the only payment source, the government essentially could impose its will on who receives care and under what circumstances. Multiple funding sources, as ASIM proposes, protect the public from too much power being concentrated in any single payer.

5. **It is fiscally irresponsible to propose a single-payer system at a time when the U.S. has a massive budget deficit.**

One proposal for a single-payer system recently introduced in Congress is estimated to cost more than $250 billion. Obligating the federal government to a massive entitlement program, at a time when there already is a huge federal deficit, is irresponsible. Public opinion polls show that of those who favored federally funded National Health Insurance, 90 percent would be unwilling to pay even $500 a year in additional taxes to finance a new national health program.[44] It is unrealistic to expect Congress to approve a plan that will exacerbate the deficit and impose a large tax burden on workers.

6. **By holding out for a single-payer system, proponents of this approach risk blocking any action on expanding access.**

In the late 1970s, an opportunity to reach agreement on a moderate approach to expand access was lost because of the insistence of some that only a single-payer national health insurance program would be acceptable. Pushing a single-payer system now risks reopening that divisive debate, with the same outcome expected. Given the growing consensus for requiring employers to offer health insurance and expanding public programs to fill the remaining gaps, it is counterproductive to reintroduce the debate over a single-payer system. This time around, many of the groups and individuals that were in conflict with each other in the past have coalesced around the approach recommended by the Pepper Commission. Let's build on that consensus, not undermine it.

An employer mandate coupled with expansion of public programs also offers advantages over alternatives that rely solely on tax breaks and the marketplace to encourage employers to offer health insurance. Tax breaks alone will not be a sufficient incentive for employers to provide health insurance. Some have proposed asking individuals to finance their own basic care, with insurance paying only for catastrophic expenses. But this approach could hinder access to services that patients would be required to pay for out-of-pocket, such as routine medical care and preventive services.

ASIM PROPOSALS - IV

Health Care Costs and Other Barriers to Access

A comprehensive plan to end separate and unequal access to care must address more than expanding the availability of health insurance coverage but also other barriers to access. Those barriers include the cost of medical care, inequitable reimbursement systems, excessive medical liability costs, and administrative and review requirements that impede access to appropriate services. ASIM offers the following specific proposals to address these barriers. More information on the rationale behind each of these recommendations is available from ASIM.

1 In order to assure that money spent on medical care is spent wisely and effectively, the medical profession, with the cooperation of government and other payers, should place high priority on studying the outcomes of different medical interventions and developing practice guidelines to modify physician behavior and to provide a basis for setting payment criteria.

Outcomes research and the development of practice guidelines must be at the core of any effort to address the cost of medical care. By providing a scientific basis for physicians to decide what works—and what does not work—in treating patients, the uncertainties of medical practice that drive increases in the volume of services can be substantially reduced. Physicians would have a basis for not providing certain services that, based on the best scientific evaluation available, are ineffective or not as effective as alternative treatments. The creation by Congress in 1989 of the new Agency for Health Care Policy and Research can provide a focal point and financial resources to support this effort. ASIM is involved with a partnership with the American Medical Association and other specialty societies to promote the development of practice guidelines.

Development of practice guidelines is a more effective approach to moderating costs than attempting to set arbitrary limits or targets on expenditures, since it gets to the heart of the relationship that largely determines the cost of care—the decisions that a physician makes on behalf of his or her patients—instead of attempting to impose overall limits on resources. ASIM is pleased that the Pepper Commission endorses the role of practice guidelines in addressing cost increases.

Once practice guidelines are widely available, however, medical care costs are likely to continue to increase due to the aging population, advances in diagnosing and treating patients, and new diseases. Practice guidelines provide payers with a reasonable certainty, however, that money is being spent only on those services shown to be effective. Further attempts to restrain costs will require a basic societal decision on whether—and how—resources for medical care should be limited, even though this may require limiting coverage for some services shown to be effective.

Caution must be exercised in imposing other cost-containment strategies that could, in fact, hinder access, by forcing or rewarding physicians for withholding needed services, by lowering payments to the point where physicians cannot afford to treat patients for the payment allowed (as is already the case with Medicaid in most states), or by setting up unneccessary administrative barriers to paying benefits for appropriate care. Moreover, the more than 30 million Americans without health insurance should not be held hostage while the country tries to find an answer to the extraordinarily difficult problem of expanding access while controlling costs.

2. Eliminate administrative hassles that impede access to care.

The "hassle factors" associated with medical practice pose a direct threat to access.

There is a growing consensus that the current methodologies instituted by payers to review utilization and appropriateness of care are overly intrusive and are not working well for patients, physicians or payers. Criteria for review is of questionable scientific validity and is typically developed with minimal professional input. Bad criteria can result in payments for needed services being denied, while inappropriate services escape scrutiny. Emphasis on sanctions and payment denials—rather than education—undermines physician support for medical review and is ultimately less effective in modifying behavior. Those physicians who practice responsible, cost-effective medicine are subject to the same intrusive review requirements as physicians with more questionable practice patterns. Claim-by-claim review often results in denials of payments for appropriate services that later are reversed on appeal. But the hassle of fighting for payment for each claim can discourage physicians and beneficiaries from pursuing payment for needed services. The barriers to paying for covered services imposed by many payers have appropriately been characterized by one author as "rationing by inconvenience."[47]

Other administrative burdens—excessive paperwork and record-keeping requirements, overly complicated rules of payment, duplicative and contradictory rules of different payers, and constantly changing requirements—also are contributing to the problem.

Since the hassles of medical practice today hit office-based physicians the hardest, it is perhaps not surprising that fewer physicians are entering specialties such as internal medicine, and more and more physicians are expressing a desire to retire early or accept administrative positions outside of direct patient care.[48] Some physicians have become so frustrated with the red tape of Medicare and Medicaid that they are likely to be reluctant to see patients covered by those programs, even if reimbursement is made more equitable.

For these reasons, any comprehensive plan to improve access must include measures to reduce the hassle factor of medical practice and to replace the present irrational, overlapping and complex system with a simplified, more fair and more effective alternative. ASIM will be releasing a comprehensive plan to reduce the "hassle factor" in the near future.

3. Institute reforms in the medical liability system.

ASIM is pleased that the Pepper Commission recognizes the role of medical liability reform in reducing medical care expenditures. We strongly support tort reform and limits on contingency fees and punitive damages as part of any effort to bring the costs of medical liability under control.

4. Require some level of patient cost-sharing in all insurance plans.

Requiring individuals to pay some share of the cost of services, through deductibles and copayments, provides an incentive for patients and physicians to use services judiciously. Varying cost-sharing by income would protect those who cannot afford significant out-of-pocket contributions, while still maintaining adequate protection over excess utilization.

CONCLUSIONS

Financing of Access and Long-Term Care Proposals

Many critics have chided the Pepper Commission for not identifying specific financing mechanisms to pay for its recommended programs. Similar criticisms can be leveled at the Basic Health Benefits Act and the recommendations in this paper.

ASIM recognizes that implementation of the recommendations in this paper will carry a large price tag. But we believe the price of neglecting those without adequate access to care is even higher. Criticism of the Pepper Commission and other similar proposals for not identifying specific funding measures is unfounded. The Commission has identified what it will cost to carry out its plan. Throughout this paper, ASIM has attempted to identify as well the potential costs of implementing our recommendations.

The issue is not the specific funding mechanisms needed to pay for the proposed expansions, but instead, whether this country agrees with the urgency of getting the job done. If there is a consensus that expanding access to care is an important national priority, then Congress can arrive at the right combination of tax increases and reallocation of spending priorities to pay for the needed expansions. But no one can argue that expanding access to Americans who now receive care under a separate and unequal system will not cost money. It is expensive, but it is well worth it.

One of the advantages of ASIM's proposal is that it asks business, government, taxpayers and patients to share the costs of expanding access to care rather than asking only one segment of society to pay the whole bill. It also is appropriate for Congress to sort through the various plans that are consistent with the recommendations in this report—particularly the Pepper Commission, the Basic Health Benefits Act and the Health Policy Agenda proposals—and decide which combination of specific changes proposed in each is most effective at expanding access at a realistic cost. Finally, setting some priorities for expansion is appropriate. ASIM believes that if limited resources preclude implementation of this entire plan at this time, making immediate interim improvements in the Medicaid program, followed by implementation of the employer mandate and a complete overhaul of Medicaid, must take initial priority over other recommendations in this paper.

But in our view, it is unconscionable for the administration and Congress to delay any longer on moving forward to end separate and unequal health care.

Let's get the job done—now.

SUMMARY

Key Access Proposals in Suggested Order of Priority For Resource Allocation

1. Make interim improvements in Medicaid eligibility, benefits and reimbursement to expand access for the poor and near-poor.

2. Require all employers to provide health insurance to their employees, institute reforms in the market for health insurance, and implement programs to provide special assistance to small businesses to reduce the cost of providing such insurance.

3. Implement measures to expand availability of private long-term care insurance.

4. Establish new federal benefits for long-term care.

5. Establish "Health IRAs" as a supplemental source of financing for medical and long-term care expenses.

TABLE

Available Annual Cost Estimates For Key ASIM Access Proposals

(In billions of dollars)

	Public	*Employers*
Expand Medicaid eligibility, benefits and reimbursement (without concurrent employer mandate)	$ 20 - 36.05	
Expand Medicaid eligibility, benefits and reimbursement (with concurrent employer mandate)	5.2 - 23.4	
Require employers to provide health insurance		
• Mandate that all employers provide basic benefit package		$ 18 - 33
• Provide subsidy to small business	0.6 - 8.4	(0.6 - 8.4)*
• Provide 100% tax deductibility for health insurance purchases by self-employed and unincorporated	1.3	(1.3)*
• Establish regional insurance program		(4.8)*
Create new federal benefit for long-term care	16 - 42.8	
Enact legislation to establish "Health IRAs"	7.9	

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* Figures in parentheses indicate savings.

Sources: Health Policy Agenda for the American People; Pepper Commission Findings, Objectives and Recommendations; Report and Background Information on the Basic Health Benefits for All Americans Act; and Congressional Budget Office Estimates on Long-Term Care Assistance Act of 1988 and "Health IRAs." See text and endnotes for details on assumptions underlying cost estimates.

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The **Chairman**. Larry Gage.

Mr. **Gage**. Thank you very much, Mr. Chairman, Senator Rockefeller. I am pleased to be here today.

I am Larry Gage, President of the National Association of Public Hospitals. I will also briefly summarize my prepared statement.

I think because the Pepper Commission Report has generated such a great deal of controversy, I think it is essential to consider the Commission's important achievements in an historical rather than hysterical context. I think that context, as you well know, Senator, is many, many years of debate over major proposals in which equally important opposition has occurred, and the perfect has in effect become the enemy of the good. We have been paralyzed over these issues in this country, not least of which during the last ten years while we have debated Federal budget deficits above expansion of social benefits.

I think against that backdrop it is perhaps less important that the recommendations of the Commission were unanimous than it is that the Commission has succeeded in moving this issue back onto the center stage, back into the spotlight.

I think in addition there are many, many specific recommendations in the Commission's report that are very meaningful and noteworthy, particularly to the safety net hospitals that I represent.

We have had the luxury of debating national health insurance rather than enacting universal coverage all these years because of the existence of a small and extremely fragile health safety net comprised of no more than 200 to 300 public and nonprofit hospitals, most of which are located in our Nation's metropolitan areas.

But I am here today to tell you that the conditions of many of these essential providers has deteriorated substantially in recent years and is now far worse than when universal health coverage was last seriously debated. As a result, I believe if we don't act quickly and vote now, our Nation's health system is facing a crisis today of unprecedented proportions.

I think it is worth illustrating this urgency by quoting to you just a few brief statistics about these safety net hospitals and their uninsured patients.

Safety net hospitals are swamped today, Mr. Chairman; they are bursting at the seams, providing an extraordinary volume of inpatient and outpatient care. Just 55 NAPH member hospitals each experienced on average over 300,000 outpatient visits in 1988. That comes to over 800 per day, and that volume is impossible to understand unless you have actually visited one of these hospitals. They are unlike any other hospitals in our health care system.

Many of the patients in the patients in these hospitals are uninsured, even by Medicaid. In 1988, nearly 34 percent of all admissions and 42 percent of all outpatient and emergency visits were unsponsored or uninsured in these hospitals.

The ability to serve this uninsured population has deteriorated substantially in recent years due to local taxpayer revolt, serious manpower shortages, aging physical plants, the crisis in trauma care, and new epidemics concentrated on the poor and disenfranchised, including AIDS, drug abuse, premature birth, and inner city violence.

Just one example. Nearly half of the 23 trauma centers designated three years ago in Los Angeles have now closed their trauma units, have given up this designation that they fought so hard to get, leading to serious overcrowding in the rest of the system. Over 50 percent of emergency room and trauma care delivered in urban public hospitals nationally is for uninsured patients. Manpower shortages and overcrowding have resulted in ever longer waits in the emergency room for uninsured patients, and you have seen many newspaper articles recently about this phenomenon, with waits of 24 and 36 hours in New York City and beginning to spread beyond New York City and Los Angeles.

Obstetric units are also crowded to overflowing. L.A. County's Harbor UCLA Medical Center, which you visited last year, Mr. Chairman, now must discharge uninsured obstetric patients just 12 hours after giving birth and their babies after just 24 hours to make room for other patients.

Nor are these problems limited to New York and California. They affect middle America as well. To give one example, 15 percent of all babies born at Kansas City's Truman Medical Center last year had traces of cocaine in their blood.

In conclusion, Mr. Chairman, we strongly urge the Congress to take immediate steps toward achieving the Pepper Commission's goal of universal health coverage and to move ahead with appropriate legislation in several other important areas as well. First and foremost, the Congress must move as quickly as possible in this session to enact legislation to expand employer coverage and also to improve Medicaid eligibility levels and payment rates. And we must begin this year to consider Federalization of the Medicaid program so that it can be expanded into a true public program.

In addition, we believe it is essential that we work together to improve the ability of safety net hospitals to carry out their current mission while we transition to full universal coverage, through such mechanisms as the creation of a national indigent care provider trust fund and new programs to address the capital and health manpower needs of our health safety net.

I appreciate this opportunity to testify, and I would be happy to answer any questions.

The CHAIRMAN. Very good. Thank you very much.

[The prepared statement of Mr. Gage follows:]

NATIONAL ASSOCIATION OF PUBLIC HOSPITALS
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STATEMENT OF LARRY S. GAGE
PRESIDENT
NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

Before the

COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

April 6, 1990

Mr. Chairman, members of the Committee, I am Larry Gage, President of the National Association of Public Hospitals (NAPH). NAPH consists of 90 public and non-profit teaching hospitals that serve as major tertiary referral centers, teaching hospitals, and "safety net" hospitals for the poor in most of our nation's largest metropolitan areas.

The purpose of your hearing today is to discuss the report and recommendations of the Pepper Commission. In my brief statement this morning, I would like to accomplish three things: 1) provide you with some general comments on that report; 2) describe the urgent need for action on many of the Commission's recommendations, by illustrating the extraordinary crisis facing our nation's fragile health safety net; and 3) suggest a number of specific steps that can be taken this year in pursuit of the Commission's vital long term goal of universal health coverage.

The Pepper Commission Report

It is no secret that the Report of the Pepper Commission has generated controversy. I believe it is therefore essential to step back and consider the Commission's important achievements -- and they **are** achievements -- in an historical (rather than hysterical) context.

Our failure to provide universal health coverage and access to care has for years been the single most important issue facing our nation's health system. It has also been one of the most important social, economic, and **ethical** problems facing all Americans -- and unfortunately, one of the most controversial as well. National health coverage is an issue that has been generating heated debate ever since Ohio's Senator Bob Taft coined the term "socialized medicine" to denigrate Harry Truman's modest proposals over forty years ago. I count myself a relative newcomer to this debate, having begun my health career in Washington by joining the staff of this Committee in 1973. However, during the period since 1973, I've counted nearly a dozen major national health insurance initiatives, offered by the most important political leaders of our era, as well as scores of more modest proposals. Unfortunately, each of these proposals seemed to generate influential opposition as well, virtually paralyzing all efforts to achieve needed reform. And by the mid-1980s, the onset of Reaganomics and our preoccupation with the budget deficit had eclipsed all but the smallest incremental efforts at improvement. As a result, despite the fact that almost everyone agrees that universal coverage is the very foundation of a humane and civilized society, we have advanced very little in this arena since the enactment of Medicare and Medicaid (indeed, many say we have fallen back several steps).

It is against this backdrop that the Pepper Commission report should be examined. It is true that the members of the Commission were not unanimous in supporting its recommendations, but what else is new? For what is extraordinarily important and commendable about the work of the Commission is that it has succeeded in moving universal health coverage back into the spotlight, in rekindling the fires of this essential national debate. Moreover, from the point of view of those safety net providers with the greatest stake in the outcome of this debate, many specific Commission recommendations are meaningful and noteworthy. We are especially pleased, for example, with the Commission's:

o Recognition that comprehensive reforms must accept and adapt to the pluralistic nature of our health system, and that different problems can generate different solutions;

o Acknowledgment of the serious inadequacies of the current fragmented Medicaid program, from its highly inequitable variations in eligibility to the failure of many states to set acceptable payment rates for hospitals, physicians, nursing homes and other providers;

o Emphasis on the importance of preventive and primary care and the need to develop and finance networks of care that provide access to services in the most humane and cost effective settings; and

o Attention to important details such as the impact of inadequate malpractice laws and policies (especially in areas such as obstetrics and emergency care) on access.

To summarize our comments, while we may not agree with its every line and comma, the Commission's report is a serious and important step forward. And given the extraordinary and worsening crisis facing our nation's health safety net, the Commission has presented the Congress with an opportunity that must now be seized.

The Current Situation of America's Health Safety Net

The gravity of the need for immediate action can be underscored by a brief look at the crises facing America's uninsured patients and the institutions that serve them. Let me begin with two general observations: First, it is essential to understand that the only reason we have had the luxury of debating rather than enacting universal health coverage all these years is because of the continued existence of a small and extremely fragile safety net; this safety net is comprised of no more than two to three hundred public and nonprofit hospitals, mostly in metropolitan areas. Second, the condition of many of these essential safety net providers has deteriorated substantially in recent years, and is far worse today than when universal health coverage was last seriously debated; as a result, our nation's health system is facing a crisis today of unprecedented proportions.

Let me illustrate the urgency of this situation with a few facts about safety net hospitals and their uninsured patients:

o Safety net hospitals are bursting at the seams, providing an extraordinary volume of inpatient and outpatient care. NAPH members provided, on average, over 300,000 outpatient visits, 19,000 inpatient admissions, and 3,500 live births in 1988.

o 55 NAPH member hospitals across the nation averaged an 81% occupancy rate in 1988, with many hospitals approaching 100%.

o Many of the patients in safety net hospitals are uninsured, even by Medicaid; In 1988, nearly 34% of all discharges and 29% of all inpatient days were unsponsored in NAPH member hospitals; over 116,000 outpatient visits on average, or 42% of all visits, were also uninsured.

o For some safety net hospitals, these proportions are far higher. For San Francisco General Hospital, unsponsored care represented 62% of all inpatient days and 72% of all outpatient visits in 1988; for Dallas' Parkland Memorial Hospital, the figures were 54% of inpatient days and 62% of OPD visits.

o Just 17% of the net revenues of safety net hospitals are derived from private insurance, while 50% of revenues come from Medicaid and direct state/local subsidies (an average of $37 million in Medicaid revenues and $29 million in direct subsidies); without direct subsidies, NAPH member hospitals would average operating deficits of over 30% -- and even with subsidies, over half still experience deficits averaging 7% (or nearly $9 million).

o The growth and persistence of these deficits have been exacerbated in recent years by new epidemics concentrated on the poor and disenfranchised, including AIDS, drug abuse, neonatal problems, and inner city violence. And the ability of safety net hospitals to cope with these new epidemics and still serve their other patients is further affected by critical manpower shortages and the inability to obtain capital for renovation, maintenance and technology.

o These new epidemics, combined with the general lack of availability to the uninsured of preventive health services, means that safety net patients are also more likely to be sicker than insured patients -- especially inner city minorities. The New England Journal of Medicine reported last year that black men in Central Harlem now have a lower life expectancy than men in Bangladesh. And here in Washington D.C., a resident of Anacostia is ten times more likely to require hospitalization for pneumonia than a resident of Georgetown.

o There are today 2,000 AIDS patients in New York City hospital beds -- patients who that essentially did not exist just five years ago. This total is projected to rise to 4,000 by 1993 or 1994. Yet there are fewer staffed beds in New York today than in 1985, and inadequate funding for treatment alternatives.

o Nearly half of 23 trauma centers designated three years ago in Los Angeles have now closed their trauma units, leading to serious overcrowding in the rest of the system; over 50% of the emergency room and trauma care delivered in urban public hospitals nationally is for uninsured patients.

- Obstetric units are also crowded to overflowing; Los Angeles County's Harbor/UCLA Medical Center, which Chairman Kennedy visited last year, must now discharge obstetric patients just twelve hours after giving birth, and their babies after just 24 hours, to make room for other patients.

- Nor are these problems limited to New York and California -- they affect middle America as well. For example, 15% of all babies born at Kansas City's Truman Medical Center last year had traces of cocaine in their blood.

- The single highest volume provider of AIDS services in the entire nation is not in New York or California -- it is Miami's Jackson Memorial Hospital, which had over 1000 AIDS admissions in 1988.

- 15% of all inpatients at Dallas' Parkland Memorial Hospital are homeless -- and nearly 50% of all inpatients who are HIV positive.

Immediate Solutions are Needed

In conclusion, in light of the history of the universal coverage debate generally, and the Pepper Commission recommendations in particular, we strongly urge this Committee and others to move ahead with appropriate incremental approaches on several fronts.

- First and foremost, the Congress must move as quickly as possible to achieve the goal of universal health coverage, enacting in this session legislation to expand employer coverage.

- It is also imperative to adopt amendments to increase inadequate Medicaid eligibility levels and payment rates, and to begin to consider the federalization of the Medicaid program.

- Since we are all aware that universal coverage will not be achieved overnight, it is also essential that we work together to craft new programs to improve the ability of safety net hospitals to carry out their current mission, such as through the creation of a national indigent care provider trust fund and attention to the needs of such providers in the context of specific legislation addressing such problems as AIDS, trauma care and drug abuse.

o We also strongly urge the Congress to consider enacting a new program to address the present and future capital needs of our health safety net infrastructure (including needed alternative care facilities in addition to hospitals); this may include a resurrection of certain aspects of the Hill-Burton program or the creation of new programs to improve access to capital. We are currently drafting such legislation and we would very much like to work with your committees in this area.

o The Congress must also continue to increase your attention to programs to meet the health manpower needs of our health safety net, and to train more minority health providers; efforts in this area should include a significant expansion of the National Health Service Corps and the adoption of new minority training programs such as those proposed by Secretary Sullivan and this Committee.

Finally, a comment on revenues: We do not agree with those who maintain that the Pepper Commission report is fatally flawed because it failed to specify revenue sources, because we all know that sufficient revenue sources exist to satisfy the need for universal health coverage, at least for basic health benefits. We must also recognize that there are long term savings to be achieved from increased attention to preventive and primary care -- something our annual budget process has thus far refused to allow us to credit. The plain fact is, the crisis facing our health system today is such that we can and must increase taxes if it proves necessary to pay for these essential health coverage reforms -- a step for which you will have the strong support of at least this segment of the hospital industry.

Once again, I appreciate this opportunity to testify, and I would be happy to answer any questions you may have.

The **Chairman**. Dr. Duvall, tell me a little bit about how health care has changed. You are a practicing physician. How do you think the situation has changed, both for society and for you personally? Do you see a rather significant and dramatic change in the patients you are seeing and the facilities that you are operating in now?

Dr. **Duvall**. Well, as Mr. Gage mentioned, there is a change in the kind of patients that are in hospitals. When people who have no health insurance arrive at the hospital, they come with different diseases; often their substrate for care is different. You may have to admit someone with diabetes and take up hospital beds to control their diabetes, whereas somebody under a sustained working relationship never has to get into the hospital, just because of uncomplicated diabetes.

A comment was made about the trauma centers closing. In this city in particular, we are heavily impacted by the detritus, the downstream effects of violence and drug addiction. All of this diverts hospitals from what would be normally their mission.

So it is mostly in the hospital setting. In the office, we have something called a personal care program where we contract with the patient at the beginning of the year to accept Medicare assignment if they can't afford it.

But really what happens, at least in my office, is I just don't see the people. They just don't show up. It is just like they don't go out and buy Cadillacs; they don't come in for medical care.

The **Chairman**. You have indicated that you support an employer-based system. Some people might say that the reason physicians' organizations support this is because you are interested in getting more fees and do not care about the burden on small business. How do you respond to that?

Dr. **Duvall**. Well, I can see that point of view, and I guess that is the risk of trying to be an advocate for these people is that you are always going to have that finger pointed at you. But I don't see a very well-organized national association of uninsured Americans, or a Canadian constituency of the sick that is operating, either.

I would expect these programs when fully deployed along the lines of the Rockefeller Commission to not be a motherload or a gravy boat for physician income. We are going to be giving up a lot of heritaged autonomy, I think, as these guidelines are deployed, and outcomes research helps focus what we can and should not do, and so our behavior is going to change substantially.

On top of that, using the gross numbers, we are going to have to work 50 percent harder.

The **Chairman**. Let me ask regarding the cost control measures, what are the physicians prepared to deal with or support? I'm giving you the hard questions here.

Dr. **Duvall**. Well, there are two ways to get the money. One is to enhance revenue and the other is to cut costs and control costs. We have been in favor right along of Senator Rockefeller's and the fall legislative approach for the Agency on Health Care Policy Review and guideline and outcome development.

I think cost savings will come from reform of the medical liability problem. I think we will see some measurable benefit from the RBRVS, where we see a tilt away from high technology, more toward the thinking and caring services. And there are other cost control measures that are already in place that are holding down costs—pre-admission certification, all those sorts of things.

But I agree that we've got enough studies. We know what will work in America, and I think we ought to be on about the business of doing it to it.

The CHAIRMAN. Mr. Gage, there are some who say that the health care crisis is really nothing more than the $8 or $9 billion worth of charity and unreimbursed care provided by the Nation's hospitals, and that we could solve the problem just by increasing subsidies. What is you reaction to that?

Mr. GAGE. Well, I don't think that that is true. We certainly would not object to increasing subsidies, and we argue for them regularly. But that is not going to solve the Nation's health insurance problem for a variety of reasons.

First, I'm not sure that the $8 or $9 billion, just in terms of care provided, is a particularly accurate figure. Judy Feder, staff director of the Pepper Commission, did a study with The Urban Institute over five years ago in which I think they found $12 billion in just the 100 largest cities in hospitals alone, about 40 percent of which was provided by the public hospitals. So I think there is a lot more uncompensated care being provided out there than that.

But we have to understand that that is just the tip of the iceberg in terms of the need for preventive and primary care which in the long run can in fact hold down health costs. There is an awful lot of care deferred out there which affects the health status and ultimately the productivity of huge segments of our population. There was a very striking figure used by Bruce Vlodick the other day in the Ways and Means Committee, which came out of the New England Journal last year, to the effect that black men in central Harlem now have a lower life expectancy than men in Bangladesh. I think that that is what is generating here in terms of pent-up need and demand for health services.

The CHAIRMAN. You mentioned earlier the types of people who are being treated in the emergency rooms of the public hospitals, and the uninsured. This is about as much of a problem if you've got insurance in terms of delays, is it not? If you go into those emergency rooms or those trauma units in New York, even insured individuals face delays. We had testimony of an executive from CBS, very successful, with the best insurance in the country, who was unable at a time of crisis to get attention in an emergency room.

Do you find this to be so—because there are a lot of people who say, "Well, I've got mine," who don't want to be having to pay more in terms of coverage for someone else, because they've got theirs. But do they really have theirs if they have an emergency, in many hospitals around the country?

Mr. GAGE. I don't think it is a coincidence that we are beginning to use wartime words to describe the situation in a number of large cities—"triage" and "diversion"—we are using military tactics to decide where the ambulances should go. And the ambulance that goes from hospital to hospital carrying a very sick patient when hospital emergency room are closed, that ambulance is not by any means always carrying an uninsured patient. The fact that we have a number of secondary problems in public and private hospitals that operate the emergency rooms and the trauma centers, the inability to get adequate health staffing and health manpower in the inner cities—Charity Hospital of New Orleans was forced recently, after losing its accreditation over staffing issues, to reduce from 600 to 450 beds; 40 to 50 percent of the AIDS patients in Parkland Hospital in Dallas are homeless, and there is a domino effect that this creates that affects access to those emergency rooms and trauma centers and also affects access throughout the metropolitan areas where these hospitals are located.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I'm interested in this whole issue of cost containment. You referred, Dr. Duvall, to outcomes research, and I think a lot of people think that sounds like some little game that some specialists sit down and play. I see it as one of the most fundamental cost containment—and perhaps the most lasting in terms of fundamental behavior modification—on the part of physicians and patients in this country.

Could you elaborate? In the Pepper Commission and indeed in physician payment reform last year, we put about $50 to $60 million into outcomes research, created a group to do that, and it is getting onstream. The thought obviously is that different doctors do different things in different parts of the country, and therefore what is really appropriate care, what is really necessary care, doctors often dispute. Rand and others say that up to 30 percent, depending upon the specialty or the problem, of medical care is either not necessary or inappropriate. Some of that is obviously caused by defensive medicine, and some of it is simply caused by the fact that doctors do things in different ways.

What do you see as the value and the process and the substance of outcomes research?

Dr. DUVALL. Thank you, Senator.

First of all, I think an integral part of this topic would be the use of guidelines or practice parameters, and I think the two themes will be interwoven as a thread to make a strong cord.

One of the problems with it is the time frame. HCFA has been mandated to get three sets of parameters or guidelines going this year. It is going to take a while to do this. And waiting for the outcome of outcomes research is to wait indefinitely. That is why I think we should move ahead now.

But more to your point, I view the outcomes research as really desired by the medical profession. We need to know more about the appropriateness of what we do. I think first it will have a terrific educational value. I think people will feel better about doing things they know have a bang for the buck. The mandate for them does come from some of the widely disparate geographic and pricing variations there are throughout the country, both in the cost of services rendered and also the prevalence of things like hysterectomies and hip replacements and this kind of thing.

It doesn't really make any rational sense, and this kind of research will rationalize something that doesn't make sense, and it will be able to do it in a cost-effective manner. Once that kind of research is onboard and described by proper parameters or sets of guidelines for care, I think the quality of care will be unmistakably better, and that for me would be the bottom line.

I think 30 percent is the number used. That comes from the single study of carotid endarterectomies. It is probably not fair to extrapolate to a nation's health care from that number. A recent study by Chasen in Minnesota looked at 6 percent was inappropriate.

I am not sure that in every area there will be cost savings. We may find we are under-doing certain things that are of very high value, but we should know that, too.

Senator ROCKEFELLER. Well, that wasn't really the answer that I was hoping for, but I obviously have to accept the answer that I got. It just seems to me—I am thinking of two women who, let's say, are pregnant. One belongs to an HMO and the other is under a less disciplined practice. They go in to get their checkups, and one gets a sonogram every month, because there is a sonogram in the office, and the other doesn't because it is an HMO, and the pregnant mother is young and healthy, and there is no need for that.

In other words, to set down what is appropriate—I would suggest that there is a lot of inappropriate care, and I don't think that that is necessarily all to be blamed on doctors, because a lot of it is defensive medicine. And I think one of the outcomes of outcomes research which leads to practice guidelines in fact will be a better defense, so to speak, against suits in court.

But I see outcomes research as having a major effect in terms of cost containment, simply because it is cost-benefit ratio that you are talking about—putting it crudely, that is what it is—doctors do not, because of antitrust—and we addressed that in physician payment reform—cannot collude to decide what are the best ways to approach things. And I think that if they are allowed to do that and do do that—and it is physicians who do it, not Congress—that you are going to see a dramatic modification—and in some cases, as you indicated, expansion—in the way physicians practice. And I think the physicians that I have talked to want that very, very much.

Dr. DUVALL. I agree.

The CHAIRMAN. If the Senator would yield on that. With regard to malpractice, the Florida Academic Task Force for the Review of the Insurance and Tort Systems reports that 3 percent of the doctors were responsible for nearly half of the malpractice awards in the State of Florida. The problem is compounded by the complexity and the difficulty that the doctors were having in disciplining these doctors, the antitrust suits they were involved in, and the difficulties of getting medical records because of privacy laws. So this is part of that extraordinary dilemma. It is just one little feature of it, but it is something that we are going to have to deal with.

Dr. DUVALL. My understanding in Boston, Senator Kennedy, is that the anesthesiology community has gotten together to draw up very specific guidelines for the appropriate use of technology and monitoring in anesthesia work and has drawn up professionally derived, well-conceived guidelines that give a clear light on the road for giving safe and excellent anesthesia. And this has dropped their medical liability experience and their premiums.

Perhaps some of the people you are referring to in Florida would not be in the middle of that guideway.

Senator ROCKEFELLER. Mr. Chairman, could I just make one additional point?

The CHAIRMAN. Yes.

Senator ROCKEFELLER. One of the things that interested me—you mentioned RBRVS in your testimony—I don't think I have read anywhere in the public program that the Pepper Commission is contemplating that all of that—the beginning of the discipline of Medicare which, because of then Medicare being $100 billion, such a behemoth, then insurance usually follows, private insurance follows closely behind.

In our public plan, all of that would be under the discipline of not only the RBRVS, but the Medicare Value and Performance Standard, and that in itself is the beginning of discipline; it is a major shifting of emphasis toward primary care, preventive care, cognitive time spent as opposed to just surgical time spent. And I think that that public program, which will obviously encompass a lot of people, under the discipline of RBRVS and Medicare Value and Performance Standard is, in and of itself, cost containment on the move. Would you agree with that?

Dr. DUVALL. I certainly would heartily agree with that. The only problem is that it is hard to put a little cost note on that. I guess it is debatable; some people would say you'll never see a penny of it. I think you will, because I think the RBRVS does straighten the warp that has existed in our system; it has fanned the technology for so many years. I think it will redirect that in a more cogent way, and I think you will see savings along the lines you have sketched. It is just hard to put a dollar footnote on it. I think it is there.

Senator ROCKEFELLER. Of course it is hard; but it is not hard to put a dollar figure on the fact that $300 billion of the $660 billion that we are currently spending in our health care system in this country is on the last three months of somebody's life. Now, of course, the difficulty of that is when is the last three months, and is it your mother or your sister. But this shift toward primary care preventive medicine I think holds enormous promise in terms of the discipline of cost and placing care where it should be and in cost-effectiveness for the future.

Dr. DUVALL. I totally agree with you.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

The CHAIRMAN. We have been joined by Senator Pell, who is an active member of the committee in shaping health policy, and we have been joined earlier by Mrs. Pell, whom we see in the audience, who I see has been taking careful notes. This is a "one, two, punch" on the health care issues; we know how interested she is and how active she has been in the State of Rhode Island on this issue.

Senator Pell. Thank you very much indeed, Mr. Chairman.

The Pepper Commission is one I think we all have come to respect a great deal, and the work that its chairman, Senator Rockefeller, and you, Mr. Chairman, as chairman of this full committee, have done to tackle the most difficult and urgent problems facing our Nation's health care system. It has produced comprehensive recommendations that deserve our immediate attention and support, and help as we try to figure out how to finance those recommendations.

I applaud the Commission's efforts; I applaud your initiatives and leadership both as chairman of the committee and as a member of the Pepper Commission. And I take particular pleasure in greeting Senator Rockefeller, who has also shown true leadership, compassion and understanding.

[The prepared statement of Senator Pell follows:]

PREPARED STATEMENT OF SENATOR PELL

Senator **PELL**. Mr. Chairman, the Pepper Commission, has issued its long awaited recommendations on our Nation's health care and long-term care system.

As you know, Mr. Chairman, the Pepper Commission, originally called the Bipartisan Commission on Comprehensive Health Care, was renamed in honor of its first chairman and champion of the elderly, the late Representative Claude Pepper. In my view, the Pepper Commission has lived up to the name it bears. The Commission has tackled the most difficult and urgent problems facing our Nation's health care system, and has produced comprehensive recommendations that deserve our immediate attention and support.

I applaud the Commission's efforts, Mr. Chairman. And I applaud your initiative and leadership, both as Chairman of this committee and as an esteemed member of the Pepper Commission, in ensuring that this committee has the opportunity to hear the views of today's distinguished witnesses.

I take especial pleasure in greeting Senator Jay Rockefeller, who has shown true leadership, compassion and understanding in his role as Commission Chairman. I look forward to working with you, Senator Rockefeller, and with you, Mr. Chairman, on addressing the very pressing need of ensuring access to quality, affordable health care for every American.

The **CHAIRMAN**. Thank you very much.

I thank the panel. We appreciate your testimony.

Dr. **DUVALL**. Thank you, Senator.

Mr. **GAGE**. Thank you.

The **CHAIRMAN**. The witnesses on our final panel bring a variety of different perspectives to the economic and policy issues involved in the proposals to achieve universal insurance.

Dr. Karen Davis is the Chair of the Department of Health Policy and Management at Johns Hopkins University and a distinguished health care economist.

Barbara Decker represents Southern California Edison, one of the Nation's largest electric utilities.

Bruce Mueller is Vice President of Corporate Benefits at Motorola and is appearing on behalf of the National Association of Manufacturers.

Carol Cronin is Vice President of the Washington Business Group on Health.

And Richard Niemiec is Senior Vice President at Blue Cross/Blue Shield of Minnesota.

We'll start with Dr. Davis. We are glad to have you back. Karen Davis is a familiar figure to this committee and has served in important positions in a variety of administrations, and we always benefit from her appearance. She has always been helpful to this committee.

We are delighted to have you back.

STATEMENTS OF DR. KAREN DAVIS, CHAIRPERSON, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, JOHNS HOPKINS UNIVERSITY, BALTIMORE, MD; BARBARA DECKER, MANAGER, HEALTH PLANS AND CLAIMS ADMINISTRATION, SOUTHERN CALIFORNIA EDISON COMPANY, ROSEMEED, CA; BRUCE MUELLER, VICE PRESIDENT AND CORPORATE DIRECTOR OF BENEFITS AND PERSONNEL SYSTEMS, MOTOROLA, INC., SCHAUMBURG, IL, ON BEHALF OF NATIONAL ASSOCIATION OF MANUFACTURERS; CAROL CRONIN, VICE PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH, WASHINGTON, DC; AND RICHARD NIEMIEC, SENIOR VICE PRESIDENT, UNDERWRITING, ACTUARIAL AND LEGAL, BLUE CROSS/BLUE SHIELD OF MINNESOTA, EAGAN, MN

Ms. Davis. Thank you, Mr. Chairman, Senator Rockefeller, members of the committee, for this opportunity to comment on the Pepper plan and its recommendations with regard to insuring health insurance for all Americans.

I find this plan a very innovative, comprehensive, balanced and pragmatic approach and think it has much to commend it.

I would also stress as other witnesses have today the urgency for action. This year is the 25th anniversary of the Medicare program. We made a lot of progress after we introduced Medicare and Medicaid in 1965. The health of our people went up; infant mortality went down; the gap between access to health care between the poor and higher income, between the uninsured and the insured, all of that improved until about the early 1980's.

During the 1980's we stagnated, and much of this progress is starting to be reversed. We saw last week, with the new report from the National Center on Health Statistics, that black male life expectancy has started to go down. In fact, the percent of black women getting early prenatal care has started to go down. Recent figures from the Robert Wood Johnson Foundation show that the gap, which had narrowed over the 1970s between the uninsured and the insured, between blacks and whites, between high income and low income, is now widening very dramatically.

I call this to your attention because I think we need to keep in mind the seriousness of the situation that we face. We are also having a deterioration. Senator Durenberger referred to the private health insurance industry as dead, or at least dying, and the exclusion of individuals who are bad risks, either totally or excluding pre-existing conditions, has reached the stage that even people who have insurance are at risk of losing that if they get really ill and need it.

So it can't wait. We can't withstand another decade of neglect like we have experienced in the 1980s. We can't wait until we get unanimous consensus on the perfect solution. We must begin to move forward. That is why I find the Pepper plan particularly a useful contribution. It has much to recommend it as a complete package; it also has much to recommend it as individual, innovative elements that could also move forward independently.

There are so many fine features of it—I'll neglect some of them, but I'd like to focus on at least four that struck me as particularly worthy of note.

First, its recommendations with regard to insurance market reform. It would prohibit the practice of excluding individuals because they have already had a heart attack or a stroke or something in their health history that makes them unattractive to private insurers. It would prohibit excluding certain conditions or having long waiting periods before those conditions would be covered. And most importantly, it would require insurers to make coverage available to all small business at the same terms, so they couldn't double or triple a premium when a child had cancer and wound up costing a plan $200,000, and then next year when the premium comes along, in order for that group to continue to cover it, they can get exorbitant increases.

So it would curb the worst abuses and I think would forestall deterioration as we are able with genetic screening to pinpoint people who are at bad risk. We also have an increase in the AIDS problem. I think if we don't do something now to curb these abuses in the private insurance, it is going to be where anyone who is going to run into any kind of serious health problem, chronic condition, cancer, whatever, is going to find themselves at risk of either not being able to get insurance or even if they have it, having it dropped or having the premiums raised. I think that is very important.

The second thing that I found very interesting and appealing about the Pepper plan was the option of letting employers and individuals purchase what I call Medicare-type public plan coverage, where employers would pay a payroll tax—it could either cover all of their workers, or if they wanted to buy private insurance for their full-time workers, they could cover their part-time workers this way—so it makes that very affordable to make a payroll tax contribution. Further, for a low-wage firm, giving them the option of simply contributing a payroll tax can be much more economically feasible for them than paying a full private health insurance premium, and of course, there are subsidies for that as well. But I think that option of getting into a public plan would be very attractive to many small businesses. They just won't have the hassle of trying to find a private I plan, don't have to worry whether it is a decent plan, what is going to happen to the premiums over time—it is predictable. You know you simply pay that payroll tax, and your workers and their dependents are covered.

The other thing that I think is very important is that this option of purchasing public plan coverage will lead to greater stability in insurance coverage. Senator Adams talked about an instance of a woman losing AFDC. She lost her Medicaid coverage if she took a job. For people who are in and out of the work force, unemployed part-time workers—not just welfare beneficiaries, but anyone who is temporarily employed, seasonally employed, working in jobs that move them in and out of employment—to be able to continue your coverage in the same plan in Medicare gives a stability that helps you keep a continuity of health care that is also very good for the delivery of health services.

In addition it lets nonworking individuals purchase this Medicare-type public plan coverage by paying kind of a fair actuarial premium or subsidized, if their income is below 200 percent of poverty. I think one of the things we have not focused on are the problems of people, say, between the ages of 50 and 64. Just employer mandate may not help some of these people. Expansion of Medicaid may not help some of these people because they have assets. But they are individuals who are retired, or having early retirement. Not all retirees have employer-provided health insurance. Some of them are disabled. We must remember you have to wait, really, two and a half years to get Medicare; you wait six months to get disability insurance, and then there is a two-year waiting period once you get on DI to get Medicare. And you also have spouses and widows of Medicare beneficiaries who don't get Medicare. So if a man at 65 getting Medicare has a wife at age 62, he may be retired and getting Medicare coverage, but there is nothing available through Medicare for her.

So it would give these older adults the option of buying into—what I would think of as buying into Medicare early, or buying into this public plan. I think that is a very important feature and very innovative and would commend the Commission for that.

The third element that I found particularly attractive about the Pepper Commission plan was its provisions with regard to low-income individuals. It would really cut the link of low-income health insurance coverage from welfare, cut the link in terms of eligibility, cut the link in terms of being administered the way it is now in many States through welfare systems, and it would establish the very important principle that everyone in this country with incomes below the level, which are quite modest, should be entitled to health care without any financial barrier to care, and furthermore that we should even provide some support on a contributory basis to people up to 200 percent of the poverty level.

I think the Federalization of Medicaid that this type of plan would bring about is very good, and to bring provider payment methods for this population group into line with Medicare, are very important elements.

Third, I would stress the importance of the plan in terms of its cost containment recommendations. I think something that hasn't gotten enough attention is extending these principles of Medicare provider payment to this new public plan that would be attracting not only low-income people, but many working people and employees of small firms into the coverage.

With the passage of physician payment reform in 1989, OBRA, the principles of Medicare cost containment would now be extended toward privately insured patients as well as public. As Senator Rockefeller mentioned, that new physician payment reform would change the relative values to encourage primary care; it would put limits on balanced billing so that no individual would face the natural hardship, and most importantly, it would condition increases in fees on performance in meeting volume performance standards. I think that is going to be a very effective device for cost control and efficiency in the Medicare program, which would now be extended to many more people.

Further, it would encourage private plans and employers to adopt these principles and approaches.

We have had other hearings on the experience of industrialized nations in health care. We know the United States spends far more than any other country. The thing that is most impressive about the experience of other industrialized nations is that they have gotten effective cost control by having a strong role for government in setting or negotiating provider payment rate. And the Pepper Commission plan moves us in that direction, toward getting a stronger role for government that would establish these principles toward a broader base of beneficiaries. It would also have the PPRC and ProPAC look at further ways in which these principles of provider payment could be extended to private plans.

There are many other important recommendations with regard to prevention, quality assurance, data systems, practice guidelines, outcomes research, all of which I think are commendable.

Finally, I find the phasing of the Pepper Commission plan particularly intriguing. It would start with children and send a clear message that our top priority is investing in the health of future generations. It puts a strong emphasis on prevention by coverage of prenatal care, well-baby care, preventive services like Pap smears and mammography. It says that the very first thing we should do is make sure that every child in this country has health insurance coverage, that every pregnant woman has coverage, so we don't have examples like the one that Senator Rockefeller mentioned in Minnesota of a woman having to give birth while trying to find a hospital to take care of her.

But beyond that, the phasing approach I think is very important in that it would make it economically and administratively easier and more feasible. First of all, it gives employers time to plan. When you've got a timetable and you know what you are expected to do over a period of time, you can make plans toward that. You can also phase in the budgetary costs for the Federal Government by taking it in steps. And by phasing you get more opportunity to evaluate and assess what is happening as you go along and either speed up or slow down if you need to various portions of it. If you see you need to go further in terms of cost containment in private plans, you can address that. If you think the reforms in the private insurance market need further strengthening, you can do that.

So I think the phasing is, again, a fairly new concept and that we can do this step-by-step in an orderly way, make a plan, make a commitment, and get there over time.

Finally, I would just say that the financing of a plan like this would be considerably more equitable. From the structure of it, you can see that they would share the burden of health care expenses among small business as well as large business, among individuals on the basis of their ability to pay, contributions by Federal Government and State governments. It would build on the administrative expertise and current programs both in terms of private insurance, and in public programs it would have effective cost control and health system reform measures.

I think it is a mistake to dismiss the Pepper plan as too ambitious, too expensive, and too economically disruptive. In fact, when you look at the cost of this plan in terms of Federal budgetary outlays of $23 billion for the access side, that is 2 percent of total Federal tax revenues. You can finance that part of the plan with tinkering in the tax system. Even modest increases in cigarette and alcohol taxes would finance half of that. It is not a major problem finding out where we would come up with an additional 2 percent in the Federal budget to take care of this problem.

Nor would there be a major economic disruption. Many people have pointed out that you would lose jobs if small business had to provide health insurance for their workers. My own estimates indicate that even without subsidies you would be talking about one-tenth of one percent of the 115 million jobs in this economy. So it is small. You couldn't observe it in an empirical study.

Plus this plan has subsidies for small business. They would pick up 40 percent of the private insurance premium. They have the option of simply paying a payroll tax to get into a public plan. So you would have even fewer job losses than that.

Plus the thing that is always neglected is that you'd have new jobs created in the health industry to provide the services to the uninsured who are now not getting the care that they need.

So on balance it is expansionary for the economy in that sense. It would create net new jobs under this. So it cannot be looked at as an adverse employment type of bill.

Many say it would cause inflation. Again, I think the Pepper plan estimates are that it would yield $15 billion in new health services for the uninsured and other individuals. That is 2 percent of our Nation's health dollar. And we have low health insurance occupancy rates, we have an expanding supply of physicians. There is no question that we have the capacity to provide this additional care without creating inflation in the health care industry.

We should remind ourselves that we are the only Nation that denies health care to people who need it based on their ability to pay. For a modest investment of our Nation's economic resources, we could assure that everyone in this country has access to health care and doesn't need to fear being wiped out financially by burdensome medical bills.

I'd like to thank the committee, and congratulate the Commission and this committee for their efforts to move us forward as a Nation. Thank you.

The CHAIRMAN. Thank you very much.

Did you know the Pepper Commission was that good, Senator Rockefeller? [Laughter.]

The CHAIRMAN. I'm not sure we're going to have a universal expression on that from the panel here, but thank you.

[The prepared statement of Dr. Davis follows:]

PREPARED STATEMENT OF KAREN DAVIS

Thank you, Mr. Chairman, for this opportunity to appear before you today to discuss the report of the Bipartisan Commission on Comprehensive Health Care (Pepper Commission) and its recommendations to ensure health insurance coverage for all Americans.

Today, I would like to stress the urgency for action -- as the accumulating evidence points to a serious deterioration in access to health care for many Americans. The Pepper Commission plan represents an innovative, comprehensive, balanced, and pragmatic approach to reversing this deterioration. It deserves serious examination and consideration.

Access to Health Care in the 1980s

This year is the 25th anniversary of the passage of Medicare and Medicaid. The year 1965 ushered in a new era of federal government commitment to improving the health of the poor and elderly and to increasing their access to health care services. Through Medicare, Medicaid, the comprehensive health center program and an expanded maternal and child health program, the poor, the aged, and the disabled began to receive the benefits of modern medicine along with other members of society.

The accumulated evidence suggests that this investment has been a contributing factor to major gains in health in the last

25 years. These gains have been especially noteworthy for children, the aged, the poor, and minorities. Medicaid, especially, has had a major impact in assisting those covered with gaining access to physician services at levels comparable to those of higher income persons with similar health problems and in improving access to prenatal and well-child care.

In the 1980s, however, this progress has begun to be reversed. Unlike previous administrations, the Reagan administration did not propose expanded coverage through a national health insurance plan. Rather, it called for major cutbacks in Medicare and Medicaid, and direct primary care delivery programs. Congress responded by attempting to protect the poor and elderly from harmful cuts in health programs. Coverage of the working poor uhder Medicaid was restricted in 1981, but the Congress subsequently expanded coverage for poor pregnant women, children, elderly, and disabled.

The absence of any Presidential leadership in support of national health insurance, however, has stymied serious efforts to make further progress in improving access to health care. The result has been a marked slowdown in further improvements in improving health of the poor, and mounting evidence of a deterioration in access to health care services.

In addition, the private health insurance market is becoming increasingly selective -- with insurers declining to cover individuals viewed to be poor health risks or instituting restrictions or waiting periods for pre-existing conditions.

Small businesses, in particular, risk having their coverage dropped if a worker or family member gets ill, or have certain individuals excluded from coverage, or find premiums raised to exorbitant levels.

The erosion of public and private health care coverage has caused a steady increase in the number of uninsured Americans throughout the 1980s. Two-thirds of this group are in families where at least one member is employed 17 1/2 hours per week or more, and a third are under the age of 18.

This decline in coverage has important implications for trends in improving health of the disadvantaged and in access to health care services. Most of the gains in improved health occurred in the period from 1960 to 1980, with relatively little additional progress during the 1980s. Life expectancy at birth and at age 65 have increased only moderately since 1980. Black male life expectancy has begun to decline. Age adjusted deaths from pneumonia and influenza are up slightly in the 1980s. The percent of black babies weighing less than 2500 grams is up slightly, and the percent of black women receiving care in the first trimester of pregnancy is down somewhat. These data suggest that progress in improving health of poor and minority population groups has certainly slowed or halted, and in some cases reversed.

A 1986 report supported by the Robert Wood Johnson Foundation points to marked deterioration in access to health care in the 1980s. According to the survey, the years 1982 through 1986 witnessed a reversal in the trends over several prior decades of improving access to health services for low-income groups. For example, the rate of physician visits by low-income and black individuals in fair or poor health decreased between 1982 and 1986. On the other hand, physician visits by nonpoor and white individuals with similar health status increased over the same period, widening a gap that had virtually disappeared prior to the last decade.

The uninsured are one-third more likely to be in fair or poor health than the nonelderly insured. Yet despite their poorer health status, in 1986 the uninsured received 27 percent fewer physician services and were hospitalized 19 percent less frequently than the insured. Further, one-fifth of the uninsured with chronic illnesses did not see a physician during the year. Fully two-thirds of the uninsured with serious symptoms (e.g. bleeding, loss of consciousness, chest pain, shortness of breath, weight loss unrelated to diet) did not see or contact a physician. One-fifth of uninsured pregnant women did not receive care in the first trimester of pregnancy. Twenty-two percent of the uninsured with hypertension did not receive a blood pressure check in that year.

Clearly, lack of health insurance coverage presents a significant threat to maintaining health and economic security. In all, 13.5 million people reported not receiving medical care for financial reasons in 1986. An estimated one million individuals actually tried to obtain needed care but were turned away. Millions of Americans are at risk of death and disability because of an inability to pay for needed health care.

I call these recent statistics to your attention to underscore the seriousness of the situation we face. This is not an issue that can withstand another decade of neglect. We do not have the luxury of waiting for unanimous consensus on the perfect solution. We must act now to begin to address this problem that robs so many of our nation's citizens of the chance for healthy and productive lives.

The Pepper Commission Plan

Other witnesses today have detailed the elements of the Pepper Commission plan. It is based on the American tradition of employer-provided health insurance coverage for workers and their families and public plan coverage for those falling outside the workplace. Building on this structure, it proposes a fundamental strengthening and integration of our mixed private-public system of health insurance coverage to guarantee coverage to all Americans. There are several innovative features of this plan which I think deserve special attention.

Insurance Market Reform

Given the deterioration in employer-based health insurance coverage, one of the most important features of the Pepper plan is the reform of the private insurance market. The plan would prohibit excluding individuals or pre-existing conditions in small group plans. It would require that the same coverage be offered to all firms on the same terms. A voluntary reinsurance mechanism for high-risk individuals would be established. These changes would go far to curb the worst abuses in the small employer insurance market, and forestall even greater trends toward denying coverage to high risk individuals.

Option of Purchasing Medicare-Type Public Coverage

Another extremely innovative feature of the Pepper plan is the option it gives all employers and all non-working individuals to purchase coverage from a Medicare-type public plan. Employers could make a payroll tax contribution to cover all workers, or part-time workers only. This would eliminate the necessity for small businesses to provide and administer an adequate private insurance plan. It would provide subsidies for low-wage firms who found the private health insurance premium excessive. It would provide a stable source of insurance coverage for part-time, temporary, and seasonal workers who are in and out of the workplace. Unemployed workers could continue their coverage by picking up the premiums based on their ability to pay.

Most importantly, retired individuals or other non-working adults under age 65 would have the opportunity of buying-in to a Medicare type plan before age 65. In many cases retirees do not receive any employer-provided health insurance, and spouses or widows of Medicare beneficiaries who are under 65 do not quality for Medicare. Even the disabled must wait at least two years for Medicare coverage. For all these individuals the option of purchasing Medicare-type coverage would be particularly attractive, and subsidies for those with incomes below 200 percent of poverty would be provided. This is an extremely important feature and should be considered for early implementation.

Low-Income Protection

The Pepper plan would replace the current Medicaid program with a universal low-income entitlement program that is not tied to the welfare system -- either in terms of eligibility or in terms of administration. All poor persons would receive coverage without charge under this new federal public plan. Near-poor persons, with incomes between 100-200 percent of poverty, would contribute up to 3 percent of income.

The principle of assuring that all poor individuals have access to health care without financial barriers is one with which most Americans would agree. The approach of permitting the near-poor to purchase public plan coverage on a contributory basis related to ability to pay is also a significant advance. This step should be further expanded to protect the near-poor elderly and disabled Medicare beneficiaries, who potentially face burdensome expenses even with Medicare coverage.

This new low-income plan would reverse some of the deterioration in the Medicaid program that has occurred as the result of budgetary cutbacks in the 1980s. Physicians and hospitals would be paid at Medicare payment rates -- replacing the substandard Medicaid payment rates but incorporating the cost containment and efficiency incentives of Medicare. This should encourage greater provider participation and reverse the trend toward refusing care to Medicaid beneficiaries.

Cost Containment and Health System Reform

The Pepper plan also contains a number of innovative features to encourage efficiency in the health care system. The most important in my view is extending Medicare's provider payment principles to a broader beneficiary base. The recently enacted Medicare physician payment reform represents a fundamental reform of physician payment in this country. It would reverse the bias toward high-cost specialty care and provide greater rewards for primary care. It would limit the financial burden to beneficiaries through limits on balance billing. It would establish targets on total Medicare physician outlays known as Volume Performance Standards to curb rising expenditures.

The Pepper plan would extend this system of payment as well as the Medicare hospital prospective payment system to all beneficiaries covered under the public plan including employment groups and nonworking individuals electing to purchase such public plan coverage. This would greatly expand the scope and effectiveness of Medicare's cost containment measures. It would also strongly encourage private plans to adopt similar provider payment methods.

One compelling lesson from the experience of other industrialized nations is that the most cost-effective health care systems are based on a strong government role in setting or negotiating provider payment rates. The Pepper plan is a significant step toward such an approach. Expanding the mandate of the Prospective Payment Assessment Commission and the Physician Payment Review Commission to develop recommendations on effective cost containment measures for both the public and private sectors is especially laudable.

In addition to these major recommendations by the Pepper Commission plan, other elements of the plan will also go far in achieving universal access to health care, including funding prevention, health education, outreach, and primary care and further developing quality assurance mechanisms.

Phasing

The Pepper plan would begin by insuring all our nation's children followed by phased implementation of insurance coverage for adults. This phasing places top priority on investing in the health of future generations by immediately assuring universal coverage of pregnant women and young children, with complete coverage of pre-natal, well-baby care, and other preventive services such as Pap smears and mammography. All uninsured pregnant women and children under age 6 would be eligible for public plan coverage, with full subsidies for those in families with incomes below 185 percent of the federal poverty level.

Coverage of working families and adults outside the workforce would be phased in beginning with incentives for smaller firms to offer coverage voluntarily, and following with mandatory coverage for larger firms and then smaller firms if coverage targets are not met voluntarily. In the final phases non-working adults would be permitted to purchase public plan coverage, with subsidies for poor and near poor adults.

This phasing enhances both the economic and administrative feasibility of the plan. It gives employers opportunities to plan for coverage of workers, and subsidizes the start-up of coverage by firms. It would give employers time to make adjustments in total compensation packages to minimize unemployment and economic disruption effects.

Another advantage of the phasing approach is that it permits mid-course corrections to be made if economic conditions change or if the demands on the federal budget or health system should prove different than anticipated. Subsequent phases can be delayed or accelerated, for example, if initial cost estimates prove high or low. Experience with the cost-containment provisions can indicate whether more stringent measures are required, or whether private and public plans are building on the best elements of managed care and provider payment currently incorporated in Medicare and employer plans. Coverage of an initial set of preventive services will provide evidence of the desirability of a broader preventive care benefit package.

Summary

In summary the Pepper plan has much to commend it, both in providing a comprehensive package and in offering innovative improvements in existing programs. It represents an equitable sharing of the burden of the cost of financing health care among large and small employers, workers, those able to afford to contribute individually to their own coverage, and federal and state governments. It builds on the administrative expertise in the private health insurance industry, while eliminating practices that have made health insurance unaffordable for many businesses. It institutes much needed health system reform measures to curtail rising costs, and shifts the emphasis in our health system toward prevention and primary care. It moves immediately to address our under-investment in the health of our children.

It is a mistake to dismiss the Pepper plan as too ambitious, expensive, and economically disruptive to be feasible in the short-term. The access recommendations would, when fully implemented, entail federal budget outlays of $23.4 billion in 1990 dollars -- about 2 percent of federal government revenues. Small modifications in the existing tax system would be adequate to finance such expanded coverage. Modest increases in alcohol and cigarette taxes, for example, could finance well over half of the cost.

Nor is the impact of the plan likely to cause major economic dislocations. My own estimates indicate that any employment loss from higher labor costs would be quite modest -- representing less than one-tenth of one percent of all jobs in the economy. Further, the Pepper Commission would give small businesses the option of making a payroll contribution to a public plan or receiving a 40 percent subsidy for purchase of a private insurance plan. This would considerably soften the fiscal impact of providing coverage and substantially reduce any employment impact. It should also be noted that any employment losses would be more than offset by the expansionary impact on the health industry -- which would expand to provide much needed health care to currently uninsured individuals.

The Pepper Commission estimates that expanded health services for the uninsured would lead to a total increase in health spending of $15 billion annually -- about 2.5 percent of current national health expenditures. With the expanding supply of physicians and hospital occupancy rates at record low levels, this new demand for health services should be easily accommodated without inflationary pressures.

While the cost and economic impact would be small relative to our nation's economic resources, the improved access to health care services would have a major impact on solving one of our nation's most pressing social problems. We are the only major industrialized nation that denies needed health care to its citizens because they are unable to afford such care. We can not afford to waste the health and productive capacity of our people by failing to invest in adequate health care for all.

I thank the Committee for this opportunity to appear today, and urge that you assume the leadership necessary to make this plan a reality for the benefit of all Americans.

The CHAIRMAN. We'll go now to Barbara Decker, who represents Southern California Edison, one of the Nation's largest utilities.

Ms. DECKER. Mr. Chairman, members of the committee, I appreciate the opportunity to appear before you today to discuss the very serious need for reform in the health care system and the recommendations of the Pepper Commission.

Southern California Edison has a great and longstanding interest in health care. As I think you might recall, Senator Kennedy, we furnish benefits to 55,000 employees, retirees and their family members. We have our own primary care clinics. We have a very large corporate pharmacy. We also self-insure and self-administer our own health benefits, including the processing of medical claims.

Because we are a sponsor of health benefits and a direct provider, Edison shares the Pepper Commission's concern with the deterioration of health care delivery in the United States.

As you mentioned earlier today the CBS executive that did not have access to care, this is exactly one of the key issues we are facing. We have to operate within the health care delivery system that is out there. We can do some things for our plan members; we can ensure that they do have medical insurance benefits that are excellent. But if there is no facility that will accept an emergency patient—they can't tell that this person has an American Express Card or an SCE Health Care I.D. Card.

We commend Senator Rockefeller and you, Mr. Chairman, and the other members of the Pepper Commission for your leadership in proposing a comprehensive package of Federal initiatives to address the problems. We urge your committee to move quickly to deal with the dual problems of cost and access.

Many aspects of the Pepper Commission's recommendations are actually consistent with our stated policy in favor of reform of the Nation's health care system. We believe reform of the system should accomplish four objectives: expanded employer-related benefits, control of health care costs, increased value for our health care dollars, broad financing for subsidies to expand coverage.

We strongly support the Pepper Commission's goal of assuring universal health care coverage for all Americans through a combined job-based and public system. At the point that costs in the health care system become reasonable and predictable—we are hoping here—we believe that all employers should be required to provide coverage for their workers and any dependents who are not already covered by another group health plan.

As part of this approach, we support the subsidies for small, marginal businesses and low-income individuals and families. We also favor the adoption of a Federally-established minimum benefit package.

Regarding cost containment, we commend the Pepper Commission for acknowledging the importance of the cost problem and the need to reduce cost-shifting to employers who now provide health insurance.

We also think many of the specific measures recommended by the Pepper Commission have merit. However, we do not believe these measures are sufficient to constrain costs. We are concerned that in the absence of immediate and effective cost controls, expanded access would accelerate the health care inflation.

Without legislation to enable private payers to concentrate their purchasing power and negotiate effectively with providers, we believe many of the Commission's reforms may simply increase the pressure to shift costs to the private sector.

We recognize the Pepper Commission's proposals will require additional Federal spending. We believe the financing of these costs should be broadly based and should not interfere with the incentives for employers to provide health insurance.

To conclude, I would like to reiterate that although Edison has been successful in controlling our own costs, we are convinced that the most significant factors influencing health care costs and quality are largely outside of our control and of any individual employer and must be addressed through cooperation between government, employers, and all the other players in the health care system.

We are pleased that the Pepper Commission has taken the initiative to propose specific recommendations for expanded insurance coverage. We urge this committee to go further and incorporate strong cost containment measures that would control rising medical costs before coverage is expanded.

We are eager to work with you to strengthen the proposals for cost containment and refine the specifics of legislation to reform our health care system.

Thank you.

The CHAIRMAN. Thank you very much. It is a very innovative and creative program at Edison, and we welcome your comments on the legislation.

[The prepared statement of Ms. Decker follows:]

PREPARED STATEMENT OF BARBARA DECKER

Mr. Chairman and Members of the Committee:

I appreciate the opportunity to appear before you today to discuss the very serious need for reform in our health care system and the recommendations of the Pepper Commission to bring about that reform.

Southern California Edison is a company with a long history of providing health services to our employees and a strong interest in ensuring the quality and affordability of that health care. We are one of the largest electric utilities in the nation, providing service to 4 million customers in a 50,000 square mile territory that includes central and southern California.

Our health care department furnishes health benefits to 55,000 employees, retirees, and their family members. Since 1903, we have run our own primary care services, and today we own and operate 8 primary care clinics and a large corporate pharmacy. In 1989, there were 60,000 patient visits in our clinics and 200,000 prescriptions processed in our pharmacy. We also self-insure and self-administer our own health benefits, including the processing of our own medical claims.

THE NEED FOR REFORM

As a sponsor of employee health benefit plans and a direct provider of health services, Edison shares the Pepper Commission's concern with the deterioration of health care delivery in the United States, as evidenced both by the growing numbers of uninsured and underinsured Americans and by the spiraling escalation of health care costs. Given Edison's longstanding tradition of providing excellent health coverage for our employees, we find unacceptable the significant barriers to medically necessary treatment for 31 and 37 million Americans with no health insurance coverage and tens of millions with inadequate health coverage.

At the root of this problem is the rapid increase in health costs which not only contributes to the growth in the numbers of uninsured, but is also causing a disintegration of essential health services. While medical inflation has been rising at nearly twice the general rate of inflation in recent years, employers' health care expenses have risen at a rate two to three times the rate of medical inflation. Our own costs at Edison have increased fourfold in eight years - rising from $21 million in 1981 to $82 million in 1988. According to HCFA, twenty years of high inflation in medical costs have driven employers' health care expenses from 2 to 6 percent of total compensation and from 9 to nearly 50 percent of pre-tax corporate profits. These escalating health insurance costs are forcing many employers to reduce benefits or cease offering medical coverage, increasing the numbers of inadequately insured individuals.

Growing cost pressures have also brought on a decline in Medicaid eligibility from 71 to 48 percent of the poverty level between 1975 to 1986 which has left large numbers of the poor without the protection of health insurance. Further cutbacks in reimbursement rates under public health insurance programs have significantly reduced the number of providers willing to accept patients covered by these programs. This has exacerbated the problems of access to medical care experienced by the poor and elderly.

The entire health care delivery system is being threatened by the growing number of people without adequate means to pay for their care. For example, over half of the hospitals in Los Angeles County's once highly acclaimed trauma network have withdrawn from the system in the last two years because they could not sustain the level of bad debt and charity care associated with their emergency rooms.

In many cases, health care providers try to offset the losses from inadequately insured patients and Government cutbacks in reimbursement by increasing their charges to private payors. This cost shifting in turn fuels the acceleration in employer health costs.

Without health care reforms to cover the uninsured and control rising medical costs, the system of employer-provided benefits that now covers 85 percent of the workforce may well collapse.

THE PEPPER COMMISSION RECOMMENDATIONS

Edison commends Senator Rockefeller and you, Mr. Chairman, and the other members of the Pepper Commission for your leadership in studying these very complex problems and proposing a comprehensive package of Federal Government initiatives to address them. We appreciate the effort that the Commission put into these recommendations, including nationwide hearings, countless discussions with experts, research by the staff, and difficult deliberations by the Members, to find a solution that might gain broad support among the American people and your colleagues in the Congress.

We believe that the solid foundation of research and proposed changes that resulted from this effort can help guide the Congress in drafting fair and effective legislation. We hope that this work will enable your Committee and the other committees with jurisdiction to now move quickly to deal with the difficult problems of cost and access.

Many aspects of the Pepper Commission's recommendations are consistent with Southern California Edison's stated position in favor of reform of our Nation's health care system. We believe a reform of the system should accomplish four objectives:

1) Expand employer-related benefits to reduce the problem of the uninsured;

2) Control health care costs by enabling government, employers, insurers and individuals to pay equitable rates to providers;
3) Enhance the efficiency, effectiveness and value of medical services by devoting increased resources to identifying appropriate and high quality care; and
4) Ensure that financing for subsidies to expand coverage is broadly based and does not interfere with tax incentives encouraging employers to provide health insurance.

Universal Access

The Pepper Commission's goal of assuring universal health care coverage for all Americans through a combined job-based and public system is strongly supported by Edison. Nearly two-thirds of the non-Medicare population is now covered through employer-based health insurance plans. A similar percentage of those who are currently uninsured could be covered if their employers provided health insurance. We believe that the most effective means of improving access to health care services for the uninsured is to extend employment-based health insurance. At the point that costs in the health care system become reasonable and predictable, we believe that all employers, including self-employed persons, should be required to provide coverage for themselves, their workers, and any dependents who are not already covered by another group health plan.

As the Pepper Commission has proposed, we believe small marginal businesses should be assisted through favorable tax treatment and specific subsidies designed to increase the availability and affordability of required benefits. In addition, individuals and small groups should be able, through the pooling of risk, to obtain health coverage on the same basis as large employers. Specific subsidies should be provided to make health benefits more affordable for low-income individuals and families.

Edison favors the adoption of a federally-established minimum benefit package. We support a benefit package of medically-necessary services that are comprehensive but not unlimited in scope. As the Pepper Commission has recommended, this package should include basic hospital and physician services, and preventive services that are proven to be cost-effective. However, we would suggest that any legislation should not encumber employers and insurers with detailed specifications such as deductible amounts and co-insurance levels. These choices should be left to the designers of plans so that creative, cost-effective alternative products may be offered to the market place.

Cost Containment

An aggressive cost containment strategy is an essential part of any proposal to improve access to health care. We commend the Pepper Commission for acknowledging the importance of cost containment and for recognizing the need to reduce cost-shifting from Government payors and uncompensated care to employers who now provide health insurance. Many of the measures proposed to control costs are measures we believe should be included in an aggressive cost containment package. Specifically, we support the recommendation that all public programs reimburse providers at a uniform rate. To end Government cost shifting to private payors, Medicare, Medicaid, and other public programs should pay their fair share of medical costs.

We support the recommendation to broaden the use of "managed care" strategies. The implementation of a series of managed care initiatives at Edison last year enabled us to save $20 million (19.6%) compared to our projection of what our health care costs would have been without the changes. While managed care can be helpful in controlling an individual employer's costs for a discrete period of time, we do not see it as the ultimate solution to our national health care inflation problem. Broader, more far-reaching changes must occur in the delivery system.

Edison also supports the Pepper Commission proposals for insurance market reform, review of the effect of medical malpractice liability on health care costs, a uniform data system to provide information on health encounters, and the appointment of a National Cost Containment Commission.

Despite our belief that specific Pepper Commission cost containment measures should be included in a comprehensive cost containment program, we do not believe the measures recommended by the Pepper Commission would be sufficient by themselves to restrain costs. We are also concerned that the Commission's access proposals would go into effect well before most of the recommended cost containment measures could have an appreciable effect. In the absence of immediate and effective measures to control costs, expanded access would increase utilization and accordingly payments to providers, quite possibly accelerating health care inflation. By putting increased financial pressure on employers and consumers, this could lead to a reduction rather than an increase in the adequacy of health benefits.

While we support the movement toward a uniform payment rate for all Government payors, a uniform public rate has limited value for private payors unless they can use a similar rate. Few private payors today are in a position to dictate payments rates to hospitals and physicians. Without Federal legislation to enable private payors to concentrate their purchasing power and negotiate effectively with providers, many of these cost reforms may simply increase the pressure to shift costs to the private sector.

Enhanced Quality and Value

Edison believes that in conjunction with efforts to limit health expenditures we need to ensure that the medical care provided yields the best value for each of the dollars that are spent. In our own programs, we have placed a great emphasis on providing the best and most efficient care possible for Edison employees, retirees and their families. We have initiated a comprehensive Quality Assurance program in preparation for accreditation by the Joint Commission on Accreditation of Health Care Organizations. This formal Quality Assurance program monitors, investigates and resolves any occurrences in both our own deliver system and our preferred provider network. By utilizing quality measures, we can enhance our preferred provider network and ensure that treatment that is rendered to Edison's plan participants represents the best available care at an appropriate price.

To build this emphasis on quality and resultant value into our National health care system, we favor an approach that would help eliminate unnecessary medical care, increase the sensitivity of consumers to the cost of care, refine our ability to identify and direct patients to high quality medical care, and improve the efficient use of new technology. The Pepper Commission recommendations reflect a similar concern about enhancing the value of health services and we support their proposals for a comprehensive national system of quality assurance and for consumer cost-sharing in the minimum benefit package.

Equitable Financing

While the Pepper Commission does not propose any specific financing mechanism to pay for increased public reimbursement and subsidies to expand coverage, we recognize that additional Federal spending will be required to implement the Pepper Commission's recommendations on access. Edison believes that the financing of these subsidies should be broadly based and should not interfere with tax and other economic incentives that now encourage employers to provide health insurance for their employees.

CONCLUSION

Southern California Edison has a long history of providing health benefits to our employees and a strong interest in ensuring the quality and affordability of that health care. In the last year, we have initiated an innovative approach to managing our health care costs which has lowered our long-range rate of increase from 23 to 14 percent. In spite of our initial success, we are not satisfied or assured that we will be able to maintain control over our health care costs in the long term. We are convinced that the most significant factors influencing health care costs and quality are largely outside the control of the individual employer and must be addressed through cooperation of all concerned parties, including government, employers, labor, consumers, insurers and providers. The first target for this cooperation should be the implementation of aggressive cost containment measures.

We are pleased that the Pepper Commission, under the able and persistent leadership of its Chairman, Senator Rockefeller, has taken the initiative to propose specific recommendations for expanded health insurance coverage. We think the recommendations are thoughtful and provide a solid foundation for the work the Congress must undertake in drafting legislation to solve our dual national problems of skyrocketing health care costs and the growing inadequacy of health insurance coverage.

While the Commission recommendations are consistent with Edison's stated position in favor of universal access and aggressive cost containment, we are concerned that the sum of the Commission's recommendations for cost containment measures would have little or no impact in moderating the ongoing escalation in health care costs. We urge this Committee to incorporate strong cost containment measures that would take effect and control rising medical costs before coverage is expanded. We believe that these measures should enable private payors to pay the same rates to providers as public payors. In the absence of convincing efforts to control health care costs, we believe it would be a mistake to expand employer-provided health benefits.

In summary, the Pepper Commission recommendations have provided an excellent starting point for a discussion of our options for expanding health coverage and controlling costs. We urge this Committee to go forward with legislation to solve these pressing national problems. We are eager to work with you to strengthen the proposals for cost containment and refine the specifics of legislation to reform our health care system.

The **Chairman**. Mr. Mueller, Vice President of Corporate Benefits at Motorola.

Mr. **Mueller**. Good morning.

We want to commend the chairman of this committee for holding these hearings today.

At Motorola, we have over 60,000 U.S. employees, and we cover about 140,000 dependents.

I am here on behalf of not only Motorola, but also on behalf of the National Association of Manufacturers, of which there are 13,500 members, of which 9,000 members have less than 500 employees.

We will keep our comments short and hope that there will be some questions during the discussion phase. The Pepper Commission is to be commended for undertaking a very ambitious and important task—to develop recommendations to improve access to health care for those under age 65. Reliance on employer mandates to accomplish this goal, however, we believe is both bad employment and economic policy.

A Federally-determined minimum benefit package is also proposed, a requirement that would thwart efforts to better manage costs, interfere with employee choice as well as the collective bargaining process.

In all other areas, we really agree with you and commend you for your recommendations regarding improved access by reforming the small group insurance market, with regard to elimination of pre-existing conditions, placing limits on premium rates, preempting State benefit mandates, and developing national practice guidelines to improve the quality of health care.

On the latter, we urge that similar work in process by various organizations and private groups be coordinated with the Federal level and that consideration be given to use of guidelines as defense in medical malpractice litigation.

We support increased attention to medical malpractice reform, with some demonstration projects. We recommend that Congress move expeditiously to bring about much-needed reform in this area.

We support the development of uniform data systems to cover all health care encounters. Like the previous speaker, we also are self-administered, and we process over 1.4 million claims—not dollars, but claims—a year for our employees, our associates and their families. We can see the variety of practice patterns, outcomes, morbidity and mortality rates in our small population. We encourage that that be developed and shared with the public, and that such systems be developed at the State level, with the inclusion of both cost and outcome data to assist both the government, the private payers and most importantly, the consumer, in making purchasing decisions based not only on cost, but also on quality.

The Commission recommends a new public plan with Federal eligibility standards to replace Medicaid. Conspicuously absent, however, is a financing mechanism needed to raise $23.4 billion to pay for the plan. We concur that an expanded public program is needed. We firmly believe that the important financing issue must first be addressed, and access must be phased in in conjunction with the focus on cost control and quality improvement.

The National Association of Manufacturers and Motorola oppose the mandating of employer-provided health benefits as a means to improve access for the noncovered. It is essential that we first deal with in an integrated fashion the fundamental problems of our health care system—an inefficient payment system, uneven quality, and appropriateness of care, defensive medicine and high medical malpractice costs.

Lack of health coverage for a large segment of our population is a serious societal problem and is of great concern to us in business. We intend to work closely with the Congress, including the bipartisan working group of Senators of the Labor and Human Resources and Finance Committees, as well as other appropriate groups, toward the important goal of reforming our private and public sector health care system.

NAM is also currently developing a new reform proposal that we will share with you in the near future.

Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Mueller follows:]

Testimony of

Bruce A. Mueller

Vice President and Corporate Director of Benefits

and Personnel Systems

Motorola, Inc.

on behalf of the

National Association of Manufacturers

regarding the Pepper Commission Report Recommendations

before the Labor and Human Resources Committee

U.S. Senate

April 6, 1990

Mr. Chairman and members of the Commission, I am Bruce A. Mueller, Vice President and Corporate Director of Benefits and Personnel Systems for Motorola, Inc. Accompanying me is Sharon Canner, NAM's Assistant Vice President of Industrial Relations. Our company employs over 59,000 people in the United States. Adding together the dependents of these workers and our retirees we provide health coverage to approximately 130,000 individuals at a 1989 cost of over $178 million.

Motorola is an active member of the National Association of Manufacturers' policy committees. I am pleased today to appear on behalf of NAM's over 13,500 member companies, 9,000 of whom have fewer than 500 employees. I wish to thank you, Mr. Chairman, for holding this hearing to discuss the Pepper Commission Report and its recommendations to expand access to health care, a subject of great concern to business. This testimony will comment on the specific recommendations to improve access to care for the under 65 only.

PEPPER COMMISSION'S NOBLE EFFORTS BUT DISAPPOINTING RESULTS

The primary purpose of the Pepper Commission, to make recommendations to improve access to care for those under 65 and to address the long term care needs of the elderly and disabled, was an important and ambitious undertaking. Senator Jay Rockefeller (D-WV), Chairman of the Commission, its congressional members and private sector appointees are to be commended for their efforts in trying to solve a problem that has eluded policymakers and politicians for decades. Indeed, the passage of Medicaid in 1966 was the promised solution which today is part of the problem. The close 8-7 vote in approving the final report points up both the political and substantive complexities of our health care system.

Critics of the report, including its vice chairman Rep. Gradison (R-OH), member Rep. Tauke (R-IO), various business groups and others, have pointed to the proposal's reliance on "mandates" as the primary vehicle for assuring access to health care. NAM and Motorola concur with this analysis in believing that mandates on employers is bad employment policy given the increased cost of hiring workers. Also, such mandates fall disproportionately on small business which is already struggling with a higher minimum wage and is concerned about proposed new mandates such as parental leave and disabilities legislation. Mandates are bad economic policy, because such practices directly add to the cost of doing business in the global marketplace, which is not borne by our non-U.S. competitors.

Missing from the report is a financing mechanism that would generate $23.4 billion ($66.2 billion, including the long term care program), the amount of revenue needed to pay for the access portion. While any financing proposals would have been controversial, some specifics could have at least provided a starting point for discussion.

Also absent from the report were proposals to address cost containment. In particular, significantly broadening access, both through increased private sector coverage and an expanded public program, would place greater demands on the system leading to cost escalation far beyond the 15-25 percent and 20-50 percent experienced by large and small companies, respectively. Further, with the new public plan in place that would cover approximately 70 million persons added to the existing 33 million Medicare beneficiaries, over 100 million people would look to the federal government for health coverage. Pressures to increase benefits would be enormous with no mechanisms in place to control that demand.

Other elements of the report make important contributions to improving access and quality of care and deserve careful consideration. These recommendations include: reform of the small group insurance market, pre-emption of state benefit mandates, 100% deductibility for the self-employed and unincorporated businesses, special tax credits/subsidies for certain small employers, development of national practice guidelines, development of a uniform data system, and demonstration projects on medical malpractice reform.

The following sections of this testimony comment specifically on the expected impact of employer mandates and Commission recommendations to improve access and quality of care.

MANDATES AND EMPLOYER HEALTH CARE COVERAGE

The Commission is to be complimented for recognizing the success of the employer-based system of benefits which today covers over 165 million Americans. However, imposing a mandate on employers could well "kill the goose that laid the golden egg." Employers who do not provide coverage would be penalized with payment of a tax. Those companies which currently provide coverage would need to redesign their plans to accommodate the required minimum benefit level and structure which would cost more.

Generally, most large businesses and many small firms offer health care coverage. A January 1989 survey of NAM members revealed that those companies with fewer than 25 employees, 96 percent offered benefits to workers and 94 percent offered such benefits to dependents as well. For larger companies the coverage rates neared 99 percent. While some self-selection in the survey may have occurred, other studies, such as that conducted by the U.S. Small Business Administration, tend to confirm these numbers.

There is some presumption that some small businesses are unwilling to provide coverage, but in reality, coverage is often not affordable or simply not available to some small firms. Given a tight labor market, there is an incentive on the part of small business to be competitive with the higher wages offered at larger firms by offering health benefits whenever possible.

On the positive side, the Commission recommends incentives such as special tax credits to assist small businesses by making coverage more affordable. This approach is consistent with our voluntary system of benefits to encourage, rather than coerce our corporate citizens to achieve desired goals.

The required employer minimum benefit package sets forth a federal standard of coverage. Arguably, employer plans incorporate many of these benefits, but mandating a so-called minimum standard will invite political pressure for added benefits. This scenario has occurred at the state level with over 700 mandated benefit laws now in place. A mandated package of benefits would thwart efforts to better manage costs and interfere with employee choice as well as interfere with the collective bargaining process. Many firms have implemented cafeteria plans which both help to control costs and give employees a choice of benefit plans best suited to individual/family needs. A federal minimum would put an end to this much needed flexibility. Also, the mandating of benefit levels without cost containment measures will increase the already spiraling costs of health care.

NAM and Motorola strongly oppose the mandating of employer-provided health benefits as a means to improve access for the non-covered. It is essential that we first deal with the fundamental problems of our health system--an inefficient payment system, uneven quality and appropriateness of care, overcapacity in some areas and undercapacity in others, and the inefficiencies of defensive medicine and high medical malpractice costs. Failure to address these problems will ultimately lead to rationing.

While some companies favor mandated benefits to "level the competitive playing field" in the U.S., raising manufacturing costs by mandating benefits would diminish American competitive strength in the global marketplace and likely jeopardize the job creation and job security of those we are trying to help.

CONSTRUCTIVE REFORMS

Small Group Insurance Market

The Commission calls for reform of the small group insurance market with regard to underwriting and elimination of pre-existing condition clauses, limits on premium rates, guaranteed acceptance of all groups, use of a voluntary reinsurance mechanism, and restricting states from regulating the content of health insurance benefits (state mandated benefit laws). These reforms would go a long way toward helping to make coverage more accessible and affordable for small firms and should be seriously pursued legislatively. While these proposals differ in some respects from the voluntary standards recently proposed by the Health Insurance Association of America, we urge the Congress and the insurance industry to work together to expeditiously enact legislation in this area.

Quality of Care

On quality assurance, the report calls for national practice guidelines and standards of care already under way by the U.S. Agency for Health Care Policy and Research/Department of Health and Human Services. We urge that work in process by the American Medical Association, Rand Corporation and other private groups be coordinated with government and business efforts and that all information be shared with practicing physicians and be made a key component of the medical education process. Additionally, the use of practice guidelines should be considered as a defense in litigation. We support demonstration projects on this issue.

Attention to the quality of care is vitally important. The Rand Corporation estimates that unnecessary and inappropriate care adds as much as 10 percent--or $50 billion annually to health costs. Quality varies across the country; for example, residents of Boston are more than twice as likely to undergo a controversial stroke-preventing procedure as residents of New Haven, Connecticut. Additional studies by Caper and Wennberg of two Maine cities reached similar conclusions for hysterectomies.

A study of coronary bypass operations in one western state found 14 percent of such procedures were unnecessary. Nationally, 230,000 bypass operations were performed in 1987 at an average cost of $28,000. Eliminating inappropriate use of this procedure could save $1 billion annually.

The use of guidelines as a defense in litigation could potentially help curb the costs of medical liability. It is estimated that malpractice premiums are about 1 percent of health costs (which totalled $600 billion in 1989) with the secondary costs of defensive medicine adding considerably to that figure. It is unclear what the legal challenges may be to this approach, but it is important to begin seriously pursuing this course of action in the fight against health care inflation.

The development of a uniform data system to cover all health care encounters has a potential to improve quality and better manage costs. However, much will depend on the structure of the system and cooperation of health care providers. Quality as measured by outcomes must be the primary concern. Once provider results are documented, purchasers and consumers can select the high-quality low-cost providers. Making purchasing decisions on the basis of quality must become the norm if we are to begin to gain some measure of control over costs.

Models already exist that would indicate the political and logistical feasibility of developing such a system. In Pennsylvania, Act 89 requires medical care providers to record both costs and outcome data for each inpatient hospital admission. These data are collected by a state agency for release to the public. Comparing outcomes for hospitals and physicians and relating this to cost clearly shows who delivered the best results at lowest cost. Less effective providers obviously must change behavior or risk losing patients. Thus, when the law is fully in place, purchasers will have an effective tool to aid in their buying decisions. Enactment of the law came about through the formation of the Pennsylvania Cost Containment Council consisting of both labor and management--the cooperation that is so essential to addressing the cost problem.

A group of Pennsylvania corporations including ALCOA, USX, and others are already using some of these outcome data to compare provider performance. Employees are given information on providers and financial incentives--in the form of reduced cost-sharing--to choose the most cost-efficient high-quality providers.

Medical Malpractice Reform

The Commission directs the Prospective Payment Assessment Commission and the Physician Payment Review Commission to convene experts to study and conduct demonstration projects related to medical malpractice reform and urges the appropriate congressional committees of jurisdiction to hold hearings. This is an area requiring major attention which the Commission has wisely chosen to highlight. Certainly, demonstrations would no doubt be useful, but much research has already been conducted. A proposal, drafted by a broad-based coalition representing business, providers and insurers, is available for consideration. There is considerable agreement that such reform is needed with the political will expressed by many to accomplish this aim. We urge the Congress to move expeditiously on this issue.

PUBLIC PLAN

The proposed public plan would replace Medicaid in part with a federal program for specific services. While noting that financing would occur through a combination of employer contributions, individual contributions, federal revenues and state contributions, there is little detail on how this would be accomplished.

We concur that federal eligibility standards are necessary to assure that place of residence not hinder access to care. Determining how to pay for this remains the major hurdle, however. But, we stand ready to work with you on determining alternatives and recommended solutions.

HEALTH COSTS AND ACCESS TO CARE

Escalating health costs must be addressed if we are ever to expand access for the uninsured. Given a national bias toward an employer-based system, which the Commission reaffirmed in its report, it is clear that Congress must seriously address the cost of health care within the context of the existing private system.

Health care costs represented over 11.5 percent of our gross national product (GNP) in 1989. From 2.4 percent of total compensation and 23 percent of total benefits in 1970, health costs grew to 5.4 percent of total compensation and 33 percent of all benefits in 1987. A January 1989 survey of NAM members confirmed that the cost of providing benefits had skyrocketed, consuming an amount equivalent to more than one-third of net profits. Offsetting quality or service gains have not emerged to justify these cost increases.

Smaller employers generally buy commercial insurance or Blue Cross coverage, both of which are subject to state mandated benefits laws. Larger employers, on the other hand, usually self-insure and are therefore exempt from state mandates. They are able to design their own coverages and cost-management programs and thus have a greater degree of control over their cost.

Small employers have little or no ability to bargain with insurers and providers and when confronted with cost increases they must face the hard choices of reducing benefit coverage, increasing cost-sharing or dropping health benefits altogether. The Will-Burt Company with 250 employees in Orrville, OH was notified last year by its insurance carrier that premiums in 1990 would rise 61 percent. (In 1989 the increase was 52 percent). Conversations with this company indicate that benefit reduction and increased employee payments are strongly being considered as well as reducing R&D and investment in equipment.

With regard to our own company, we have implemented most of the state-of-the-art in cost management and managed care techniques, yet we continue to incur yearly cost increases in the 10-12 percent range, and that affects Motorola's competitiveness within a global economy. Such health care costs surely impact the competitiveness of other companies, and ultimately, consumers are affected through the cost of goods and services.

It is estimated that by the year 2000 health costs will reach 15 percent of GNP, up from nearly 12 percent today. Such yearly cost increases cannot go unchecked indefinitely without seriously damaging the ability of American business--and its employees--to grow and prosper and compete globally.

CONCLUSION

The Pepper Commission endeavored to address the problem of access to health care through mandates on employers--an approach that is inherently flawed given its adverse job-creation and economic impact. Improvements to the small group market for insurance, other incentives for small firms, medical malpractice reform, and attention to quality assurance are important recommendations that deserve careful congressional attention. The difficulties encountered by the Commission point up the enormous complexities of the U.S. health care system, both politically and structurally. Hopefully, lessons learned will guide other groups, such as the Advisory Council on Social Security, the President's Domestic Council Policy Review and the HHS Task Force in seeking solutions to expanding access and addressing the problems of the cost and quality of care.

A working group of bi-partisan Senators from both the Labor and Human Resources and the Finance Committees have developed an options paper on these issues. It is our intent to work closely with that group and continue the process on reform undertaken by the Commission.

Motorola, Inc. and the National Association of Manufacturers believe that reform of our health care system must focus on cost control and quality improvement, particularly in the buying decisions for health care, in conjunction with a phased expansion of access for those who do not have health care coverage. Lack of health coverage for a large segment of our population is a serious societal problem and of great concern to business. It is our view that costs, quality and access should be dealt with in an integrated fashion, without mandates. We encourage the Commission staff to meet with us to review alternative proposals for these important areas.

SUMMARY

The Pepper Commission is to be commended for undertaking a very ambitious and important task to develop recommendations to improve access to health care for the under 65. Reliance on employer mandates to accomplish this goal, however, is both bad employment and economic policy. A federally-determined minimum benefit package is also proposed--a requirement that would thwart efforts to better manage costs and interfere with employee choice as well as the collective bargaining process.

In other areas, we concur with the Commission recommendations to improve access by reforming the small group insurance market with regard to elimination of pre-existing conditions, placing limits on premium rates, and preempting state benefit mandates; and developing national practice guidelines to improve the quality of care. On the latter, we urge that similar work in progress by various private groups be coordinated at the federal level and that consideration be given to use of guidelines as a defense in medical malpractice litigation. We support increased attention to medical malpractice reform with some demonstration projects, but recommend the Congress move expeditiously to bring about much-needed reform in this area.

We support the development of a uniform data system to cover all health care encounters. Such systems should be developed at the state level with the inclusion of both cost and outcome data to assist both government and private payers in making purchasing decisions based on quality.

The Commission recommends a new public plan with federal eligibility standards to replace Medicaid. Conspicuously absent, however, is a financing mechanism needed to raise $23.4 billion to pay for the plan (access to care for under 65 only). We concur that an expanded public program is needed, but firmly believe that the important financing issue must first be addressed and access must be phased in, in conjunction with a focus on cost control and quality improvement.

NAM and Motorola, Inc. oppose the mandating of employer-provided health benefits as a means to improve access for the non-covered. It is essential that we first deal in an integrated fashion with the fundamental problems of our health care system--an inefficient payment system, uneven quality and appropriateness of care, defensive medicine and high medical malpractice costs. Lack of health coverage for a large segment of our population is a serious societal problem and of great concern to business. We intend to work closely with the Congress including the bi-partisan working group of Senators of the Labor and Human Resources and Finance Committees as well as other appropriate groups toward the important goal of reforming our private-public sector health care system. NAM is currently developing new reform proposals which we will share with this committee in the near future.

The CHAIRMAN. Carol Cronin, Vice President of the Washington Business Group on Health.

Ms. CRONIN. Thank you.

We would first like to commend the Pepper Commission members and staff for their work on health care system reform. We do acknowledge that there were many unanswered questions in the recommendations, particularly in terms of how it will be financed, but we applaud the Commission for taking the time to really do an analysis of what it would cost even though the numbers generated are quite sobering.

I think the substantive change in the whole area of health care reform has to be preceded by a vision of where you are going—I think that is what you were saying, Senator Kennedy—and we certainly share the vision of the Pepper Commission that what this country needs is a system that provides universal access for all American citizens.

We also agree that that system will be a public/private partnership which will include individuals, the private sector, and government. However, I need to communicate that there is a difference of opinion within the business community, as I think was exhibited on the panel this morning, in terms of how that responsibility should be allocated amongst those partners.

I don't think I need to tell you that American business is reeling from health care cost increases. Average increases expected for 1990 are probably 20 percent. While business shares your vision of universal access there is, as I said, a lack of consensus on how to attain that goal. We recognize the effect of cost-shifting amongst the public sector and the private sector and within the private sector; however, there seems to be a more fundamental concern, which was also captured this morning in the discussion, about what we are providing access to, what kind of health care delivery system we are providing access to and how do we control the costs in that system.

With reference to the particular recommendations, we are very supportive of the expansion of the 100 percent deductibility. We are very interested in the insurance market reform—very interested. We feel that the tax credit and subsidy for the cost of health insurance for workers would also stimulate voluntary coverage. We certainly support the expansion of managed care to small groups. Quality assurance is something we have been very interested in for the last several years. We particularly note the uniform data system, and we would make a note here that such data will really only be effective in an information-driven society like ours if in fact it is made available to purchasers and consumers in a comprehensible fashion.

We were disappointed that the Commission did not go further in terms of malpractice. As appended to our written testimony, we do have a proposal that represents a consensus employer opinion on malpractice, and we commend it to your attention.

We were pleased to see that there was an emphasis on health promotion. Again, that is a longstanding interest of the Washington Business Group on Health.

I guess the heart of the matter is the employer mandate, the "pay or play". I guess in the minds of many employers, as I mentioned before, the key question that keeps coming up is what are we providing the citizens access to, what kind of health care systems. And the answer to that question involves really two contradictory answers. One is a system marked by overutilization, overtreatment, skyrocketing cost, lack of accountability; and on the other hand, it is a system marked by total inaccess to certain people.

While we recognize the importance of reducing cost-shifting which results from this, we also want to support a strategy that rationalizes and stabilizes the overall costs to all payers rather than simply trying to talk about how to distribute burdens.

We also recognize that it is incumbent upon the business community, who has had some experience in this area, to try and come up with ideas about how to do that, and we are committed to doing that through our Health System Reform Committee, through our Board of Directors and through the National Business Coalition Forum, which is a coalition of coalitions from around the country.

In summary, I need to State that opposition to Federal mandates amongst even large business continues to remain strong, although I would say that this also is a period of great re-examination. I think a lot of employers have come to the same conclusion that Barbara has, which is that they can't do this by themselves, that they need to look at State health policy and they need to look at Federal health policy. So I think there is a greater willingness now to consider a broad range of alternatives in addressing cost, quality and access than there ever has been before. And I think it probably parallels your own efforts through your Working Group. I know that we are taking very seriously the options paper that was generated by that group.

Just in summary, Senator Rockefeller, we are very sensitive to the issue that you raised about holding the uninsured hostage while we try and solve the cost problem. And I think we are not advocating in any way inaction. We think that there is a lot that can be done right now in terms of the health insurance market reforms and all the different proposals that you have that look at small business. Let's do it, let's try it. We are very great advocates of Medicaid expansion.

We feel that the quality work which you have also been very involved in will have payoffs, hopefully maybe even in the short term.

So I think there are things that we can do right now. I think if they don't work, if in fact the voluntary approach doesn't work, then I think employers will very seriously consider the need to look at other more what they would consider dramatic strategies.

Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Ms. Cronin follows:]

PREPARED STATEMENT OF CAROL A. CRONIN

INTRODUCTION

My name is Carol Cronin and I am Vice President of the Washington Business Group on Health (WBGH). WBGH is a non-profit health policy group which involves large employers in the development of federal health policy. We appreciate the opportunity to comment this morning on the Pepper Commission recommendations.

We would first like to commend the Pepper Commission members and staff for their work on health care system reform. We acknowledge that there are many unanswered questions related to the recommendations - particularly on its financing. However, we applaud the Commission for seriously studying the costs of their plan, while recognizing that the numbers generated by your staff are truly sobering.

Substantive change must be preceded by a vision of where that change will take you. The WBGH shares the Pepper Commission's vision that what is necessary in this country is a system of health care that provides universal access for all American citizens. We also agree that the system will involve participation by individuals, employers and the government, though the exact allocation of responsibilities is still the subject of debate within the employer community.

American employers are reeling from the effects of the costs of health care. A recently released survey by Business and Health magazine found that concern about the rising cost of health care far outranked any other health care issue, with 92% of respondents saying they are very concerned. The survey found that expected premium increases for 1990 averaged 20% over the previous year.

While business shares your vision of universal access, there is a lack of consensus on how to attain that goal. Employers who offer health insurance recognize that the number of uninsured and the multiplicity of payers in this country affect their costs through various forms of cost-shifting. There is a more fundamental concern, however, that the health care delivery system itself - what any access proposal would provide access to - is flawed and must be altered.

COMMENTS ON SPECIFIC PEPPER COMMISSION RECOMMENDATIONS

We would like to offer some preliminary reaction to specific recommendations contained in your report:

Assistance for Small Business

The Commission has appropriately recognized the importance of addressing small business' challenge of providing health benefits for their employees and dependents. This section of the business community which provides the great bulk of new jobs operates at a significant disadvantage. If self employed or unincorporated, the tax deduction enjoyed by large business is denied. The cost shifting back from Medicaid, Medicare and any other payer who does not pay its share stops here. On top of that insurers must pass on the high costs associated with more frequent business failure, high administrative and marketing costs, and alleged adverse risk selection.

The WBGH has long supported the 100% deductibility of health care premiums for the self-employed and unincorporated businesses. Certainly expanding the current 25% deduction and making it permanent will make the purchase of health care more attractive to many of these small businesses.

We anticipate that some of the insurance market reform recommendations would also make health insurance more attractive to small businesses. The provisions which would prohibit denial of coverage for any individual in the group and which would guarantee acceptance of all small groups wishing to purchase insurance are particularly noteworthy.

The 40% tax credit/subsidy for the cost of health insurance for workers and their dependents for employers with fewer than 25 workers and an average payroll below $18,000 should also stimulate voluntary coverage by small businesses. We would be interested to know if the Commission had access to any market studies which indicated that small employers would indeed purchase insurance if such an incentive was available. If not, we would urge that such studies be conducted.

Finally, we support the recommendation that managed care plans would be required to be offered to small groups if such plans are available to larger employers in the area. We note that the managed care industry is still in its infancy and needs to learn more about the small business community.

Quality Assurance

As long-time advocates of the importance of quality in the health care purchasing decision, we applaud the Pepper Commission's recommendations in this area. A comprehensive national system of quality assurance must include the evolution of effective practice guidelines, standards of care and measures of outcomes. If such standards existed, providers would probably be better protected from malpractice suits.

The development and implementation of a uniform data system that covers all health care encounters is one of the most important recommendations in the report. The WBGH has strongly supported the use of data to determine the quality and effectiveness of medical care. Such data will, in an information driven society such as ours, only be effective if it is accessible and comprehensible to purchasers and consumers.

We would also note that there will need to be a massive education campaign targeting consumers with regard to the quality of medical care. Individuals will increasingly be faced with the need to understand and make choices about the care they receive. Currently people incorrectly believe that more health care and more expensive health care equals better health care. Employers are aware of their role as an important conduit for disseminating quality of care information and urge the federal government to provide leadership on mounting a comprehensive consumer education campaign.

Delivery Issues

The WBGH agrees with the Pepper Commission's observation that expanded health care insurance coverage should reinforce, not replace, support for primary care delivery systems targeting the poor and underserved. We are committed to increasing the visibility of, and support for, organized primary care providers (e.g. local health departments and community health centers) within the business community.

We also support your recommendations calling for a reduction in organizational and bureaucratic barriers to access and the development of outreach and facilitating services. We recognize that it may not be enough simply to increase eligibility standards and reimbursement rates in programs serving the poor and near-poor if other constraints prevent those eligible from actually using the programs. There is perhaps much that can be learned from the business community on how to design systems that are based on "customer service".

Finally, we strongly endorse your recommendation on the need to support programs for health promotion, disease prevention, risk reduction and health education and the corresponding recommendation for increased spending in this area. The WBGH is committed to the important role that worksites can have in accomplishing this mission and can serve as a resource on this issue through our newly established National Resource Center for Worksite Health Promotion and the Prevention Leadership Forum.

Public Plan

We have long endorsed the need for a uniform national eligibility standard for the Medicaid program set at the federal poverty level and we increasingly recognize the need to address Medicaid reimbursement rates for providers, which if unaddressed will continue to create access problems for Medicaid recipients. WBGH needs to further discuss the pros and cons of establishing a new public program for low income Americans versus improving the existing Medicaid program.

Employer Responsibilities/Cost Containment Initiatives

It is in these two areas of the Pepper Commission report that we have the most concerns. In the minds of many employers, access to health care and the cost of health care are inextricably linked. If we are going to bring millions of citizens into the existing health care system, we must address the economics of that system. The question is raised, "What are we providing citizens access to?". The answer to that question in the minds of many employers involves two contradictory extremes: on the one hand, access to a system marked by over-utilization and over-treatment, skyrocketing costs, and lack of accountability; on the other hand a system that is partially or totally unavailable to a significant number of American citizens. While we recognize the importance of reducing the cost-shifting amongst the public and private sector, and between different businesses within the private sector resulting from these contrary trends, we would like to support a strategy that stabilizes the overall cost to all payers of health care rather than simply redistributing the ever-burgeoning costs.

Efforts to address the costs of health care have been a top priority for companies over the past several years. Candidly, these efforts have not always been as successful as hoped for, in large part because they may not have been addressing the right questions. For example, rather than focussing on the site of a procedure (in-patient vs. out-patient) or whether a length of stay was appropriate, the essential cost management question, previously unasked, is whether the procedure should have been performed in the first place. Accordingly, cost and quality have also become inextricably linked in the minds of employers. Poor quality care and poor quality care providers are ultimately more expensive than good quality care and good quality care providers. As noted above, the Pepper Commission has recognized the importance of quality in their recommendations and rightfully lists it as a cost containment initiative.

Given the central importance of health care cost issues to the employer community, the WBGH recognizes that it is incumbent on the private sector to be more specific about what cost management strategies we think will work. We need to better understand what components of managed care have been successful, whether they in fact are applicable on a broad basis, and whether and what type of government intervention may also be necessary. Through our Health Care System Reform Committee and Board of Directors, we are committed to generating discussion and debate on these issues. We are also monitoring the innovative cost management programs underway in various communities and states nationwide through our National Business Coalition Forum - a coalition of local, state and regional health care coalitions. We will certainly share our findings with members of this Committee and the Pepper Commission.

In summary, we feel compelled to state clearly that opposition to federal mandates among large businesses remains strong. The potential benefits of such an approach to companies that already offer health insurance currently rank behind other more critical issues.

Malpractice

We were disappointed in the Pepper Commission's recommendation for more study of malpractice. Employers feel strongly that it is time for actual reform of the medical liability system and support a federal approach. WBGH has recently released a reform proposal that is appended to this statement. We feel it seeks a reasonable balance between political acceptability and technical design on the federal level. We urge strong consideration of this proposal.

CONCLUSION

In summary WBGH recognizes that we are entering a new period in which the entire health care system will be examined and is subject to basic reforms. In part the pace of change will be determined by the degree of perceived crisis on the part of the American public. The costs of health care to employers is pushing the issue up the list of priority concerns for senior management in American corporations. At this point, the insured American public is still largely shielded from the spiraling costs of care, however, increasingly employers will shift costs to employees, dependents and retirees. While many view cost-sharing as a legitimate method of involving employees in health care decisionmaking, excessive shifting may generate the type of backlash which precedes political action.

We support the Pepper Commission's approach of offering a multi-year strategy, as we believe that, in the absence of a broad-based public outcry on health, an incremental approach to change will be necessary.

We appreciate the opportunity to testify this morning, commend the Pepper Commission for recognizing the many issues needing to be addressed, and the time it will take. WBGH looks forward to a continued dialogue on these important issues.

MEDICAL MALPRACTICE REFORM: A BUSINESS PERSPECTIVE

DISCUSSION DRAFT - FEBRUARY 1990

INTRODUCTION

The Washington Business Group on Health (WBGH) has been involved with the medical malpractice issue since 1976 when the primary concern of employers was the impact of increasing liability insurance costs on health care premiums. The cost of medical malpractice affected physicians and patients alike as the spiraling increase in the frequency and severity of medical malpractice lawsuits resulted in increased premium costs to physicians. Physicians offset this increase by elevating their fees. They also began to engage in defensive medical practices, such as ordering more diagnostic tests to reduce their exposure to lawsuits. It has been estimated that 20-30% of the tests performed by physicians are for defensive medical purposes such as creating a performance file in case a lawsuit is filed. It has also been estimated that these defensive medical tests cost \$15-40 billion a year[1]. As the charges to patients increase, the price of health insurance naturally goes up for patients and/or their employers. Ultimately, it is the purchaser of health care who is paying for the cost of medical malpractice.

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[1] Professional Liability in the 80's, Report 1, American Medical Association Special Task Force on Professional Liability and Insurance, October 1984, p.3.

When the malpractice problem first gained the attention of the employer community there was no consideration of the potential issues encompassing employers as purchasers of medical care. At that time, employer attention was primarily focused on corporate cost management strategies which began to be implemented as a response to the rapid health insurance premium increases of 1976-1979. The major objective of these strategies was to reduce the rate of premium increases for employers. Little thought was given to long term cost management strategies, to the relationship between private health care expenditures and public health programs, or to the quality of health care. Since the mid to late 70's, cost management techniques have become increasingly sophisticated as illustrated by the use of: utilization review; data systems for severity analysis and appropriateness; specialized protocols for the purchase of transplants; in-house health care providers; investments in preventive services; and preferred provider organizations (PPOs).

Employer interest in medical malpractice has increased for several reasons:

1. Health care costs continue to rise.
2. There is evidence that the states have not been able to solve the medical malpractice problem.
3. Diminished liability insurance availability has resulted in reduced access to certain categories of physicians (e.g., Ob-Gyn) especially in rural areas. This is seen as a significant problem for an increasingly female workforce.

Today, health care purchasers are becoming more concerned about the medical malpractice issue as they search for ways to control their increasing health care costs. Also, health care purchasers are now expressing an interest in medical malpractice reform because of their need to buy high quality health care for their employees at a reasonable cost. Purchasers are increasingly aware that they can no longer afford to be concerned only with the cost of care provided. Their purchasing, reimbursement and management decisions directly influence the quality of care provided as well. This awareness is taking place in the absence of any system of publicly recognized and accepted standards to define the concept of quality of care, and in an increasingly litigious medical malpractice environment.

The medical malpractice system as it exists today has become an obstacle to the goal of assuring accessibility to high quality, cost effective health care for all who need it. Any attempts at resolving the malpractice problems must be directed at lessening this obstacle. This reform must also be supported by the development of practice guidelines which will contribute to a higher standard of care being practiced by physicians and purchased by employers; and may constitute a defense against malpractice.

COMPONENTS OF MEDICAL MALPRACTICE PROPOSAL

There was consensus among employers in attendance at a medical malpractice seminar jointly hosted by WBGH and the Health Resource Services Administration (HRSA), an agency of the Department of Health and Human Services, that the medical malpractice problem should be solved at the federal level. In the Fall, 1989, a WBGH Medical Malpractice Task Force met to draft an employers' package on medical malpractice reform focusing on federal reforms. Once again, employers insisted that the reform package include federal pre-emption of state tort laws.

It is WBGH's belief that employers as purchasers of health care must take a leading role in this medical malpractice policy discussion because of its importance as a key component of any national health reform plan. The following provisions included in the proposal were agreed upon by the Medical Malpractice Task Force and later approved by the WBGH Board of Directors:

A. Arbitration

Arbitration panels should be established within the jurisdiction of state government to review medical liability claims. The panels would be broad-based and would include physicians, especially but not only those in the same specialty as the physician in question. By placing physicians on the panel, peer professionals would be able to determine what level of quality of care was used by the defendant physician. The arbitration process would provide for an expedited review process for all claims filed and would be mandatory for all persons seeking redress. Incentives must be placed into the system to discourage persons from seeking judicial review of the panel's decision. For example, if the losing party sought appellate review of the panel's decision, he would pay the costs of the entire proceedings if he lost at the appellate level. The arbitration process would be self-funded as the litigants would share in the costs of the proceedings. The arbitration process must be established to resolve claims within a certain period of time such as one year from the time a claim is filed, barring unusual circumstances.

1. Certificates of Merit are also advocated by WBGH and could be tied to the arbitration process. This type of pre-screening device would require a plaintiff's attorney to have his case against a health care provider reviewed on its merits by a designated expert. The attorney would have to sign an affidavit stating that the case had been reviewed by an expert and the expert had concluded the case could have merit. Since the record may not be complete prior to discovery, a consulting expert is not required to certify that malpractice in fact has occurred, only that there is some reasonable cause to believe that malpractice may be indicated based on the available facts.

B. Establishment of Practice Guidelines

Employers face the tasks of purchasing, reimbursement and management of healthcare which directly influence the quality of care provided as well. These tasks are made all the more difficult by the notable absence of agreed upon medical practice guidelines.

For employers, the unit price of medical care is not as economically significant as obtaining high quality care. A good medical malpractice system, according to WBGH employers, would contribute to the development of reasonable standards that could be used as guidelines for purchasing health care. In addition, if standards existed, providers would be better protected from suits or large damage awards based upon such controversial and inherently unscientific concepts as community standards of practice. Adherence to such standards by physicians would be an effective defense to a malpractice claim. For example, if a physician could prove that he followed a prescribed set of guidelines for a particular procedure by going through each specific guideline one by one, a physician could prove that he did not fail to use such care as a reasonable and prudent physician would use in similar circumstances.

No matter what happens with the medical malpractice system, the demand for medical standards is increasing and will become much more intense in the upcoming years. Employers and consumers want to know that the health care provided is appropriate, not just that a procedure is properly performed. Purchasing by quality standards is a philosophy that is currently ahead of the technology necessary for full implementation. However, it is a necessary component essential to the success of medical malpractice reform and will continue to be advocated by the purchaser community.

C. Cap on Non-Economic Damages

A cap on non-economic damages must be included. These damages include: pain and suffering, loss of consortium, and mental anguish. Employers believe these types of damages should be capped at a reasonable amount because they are difficult to ascertain accurately and are the primary cause of the unpredictability of awards. Many states have determined that a $250,000 cap is a fair and equitable amount and WBGH is in agreement with this amount, although the principle rather than any specific amount, is the primary objective.

D. Periodic Payments of Future Damage Awards

This reform requires that compensation for future damage awards of $100,000 or more (including lost income, and medical expenses) would be paid in periodic payments. Non-economic damages (including attorney fees) would be paid as a lump sum award. This type of reform would guarantee a steady flow of income installments to injured plaintiffs as their medical costs are incurred and their wages are lost, rather than a lump sum award.

Medical expenses would be paid in the form of scheduled payments determined by a court to be paid over the estimated lifetime of an individual or until the total amount of such award is paid, whichever occurs first. If an individual dies prior to the date on which the final payment is to be made, the scheduled payments for medical costs would cease.

Periodic payments for income maintenance would also be made in the form of scheduled payments to be paid over the lifetime of an individual or until the total amount of such award is paid, whichever occurs first.

An alternative to scheduled payments which would cease upon the death of an individual, is the use of a Joint and Survivor Annuity. Under this provision, periodic payments for income maintenance would be paid in the form of a Joint and Survivor Annuity.

In proposing this reform, WBGH is addressing the high costs incurred by insurance companies in which lump sum amounts are awarded to a plaintiff. Cost savings result under this type of reform by permitting insurers to finance future awards through the purchase of annuities and eliminating windfall gains if an individual's life expectancy is shorter than the court concluded it would be. WBGH believes in the concept of adequately compensating an individual for damages incurred by a malpractice action. However, it is widely believed that periodic payments will lower the total cost of malpractice, while also benefiting the plaintiff by providing payments over time.

E. Mandatory Offset Against Award Equal to Collateral Source Award

The collateral source rule is a Rule of Evidence prohibiting the introduction of any evidence to a jury that a patient has been compensated or reimbursed for his injury from any source other than the defendant. Therefore, plaintiffs often receive a double recovery; one from an insurer or employer, and one from the defendant. WBGH advocates the elimination of the collateral source rule.

In addition, employers advocate a mandatory offset against any jury award for compensation in an amount equal to the amount received from any collateral source. A mandatory offset directs the judge or jury to subtract any payments from health insurance or similar plans from the liability award.

Employers are also particularly concerned about not being subrogated to the payments that they have already made to the plaintiff, i.e. workers' compensation payments. Because of this concern, the mandatory offset should not include any such payment or benefit that is the subject of a claim of subrogation, reimbursement or lien. Alternatively, the judge hearing the case could determine a schedule of payments, making sure other payers' sources who have already compensated the plaintiff are reimbursed for those payments before the plaintiff receives his compensation.

F. Joint and Several Liability

Under the doctrine of joint and several liability, parties to a liability action may be sued separately or together at the plaintiff's discretion. The effect, when one or more defendants are without resources, may be to require a defendant with a limited role in causing an injury, but with a "deep pocket" to bear a disproportionate share of compensating the plaintiff.

Therefore, WBGH advocates elimination of the joint and several liability doctrine which would relieve defendants of this unfair burden in these types of situations, except in the limited circumstance where the plaintiff can demonstrate that the defendants have actually acted in concert to cause the plaintiff's injury. WBGH is particularly concerned about situations where a physician who has never treated a patient is sued based on his partnership relationship with a treating physician or because he has seen the patient once on behalf of the treating physician.

G. Statute of Limitations

Employers recommend adopting a two year statute of limitations that begins at the time the claimant discovered or should have discovered both the harm and its cause. This would alleviate the possibility of a lengthy delay between the occurrence that gave rise to the claim and the actual decision regarding the claim. In addition, there is the possibility of loss of evidence during a lengthy delay which would be avoided by adopting a two year statute of limitations.

The provision should also include an exemption for minors under six years of age. The statute of limitations does not begin to toll until a child reaches his or her sixth birthday. It is felt that abnormalities resulting from any injury will be easier to detect once a child becomes school-age.

H. Attorney Fees

Employers are aware of the problems inherent in the contingency fee arrangements for attorneys and believe reform will return a larger portion of the damage award to the victim or even reduce the actual total award. Any legislative proposal on medical malpractice should address these problems. However, the WBGH is not in favor of total elimination of contingency fees. If contingency fees were eliminated, access to the legal system for those persons who can not otherwise afford care may be compromised. One possible alternative to a contingency fee system is a sliding fee schedule. A schedule could be established which would limit attorneys' fees to 50% of the first $50,000 of any award, 33.33% of the next $50,000, 25% of the next $100,000 and 10% of any further amounts in excess of $200,000. If contingency fees are allowed under such a system, certificates of merit would be mandatory.

CONCLUSION

It is apparent to the WBGH Board and its member corporations that reform of the medical malpractice system is a necessary element of any national health reform plan. WBGH believes that the climate is right for increased employer leadership in medical malpractice reform. In the past, the issue has placed physicians and insurers against the trial bar with employers and labor on the sidelines. WBGH believes a definite role now exists for employers and labor to be active players in this important policy discussion. Employers have targeted reform of the health care system as a priority issue for the upcoming years and medical malpractice reform is an important and necessary component of this objective. WBGH members are convinced that the best solution to the malpractice problem is federal reform of the system embodying the components discussed above.

The **Chairman**. Richard Niemiec is Senior Vice President at Blue Cross/Blue Shield of Minnesota.

Mr. **Niemiec**. Chairman Kennedy and members of the committee, I am very pleased to be here today.

Blue Cross and Blue Shield of Minnesota is the largest writer of health care coverage in Minnesota, serving over 1.1 million Minnesotans with a variety of coverage options, including managed care, fee-for-service indemnity programs, and our HMO, Blue Plus. We insure about one-fourth of the State's population, with the majority of coverage we write in the rural areas.

In order to provide cost-effective coverage, we aggressively negotiate provider contracts and develop case management strategies to control costs. I would be glad later to respond to questions about our cost management strategies.

We have to deal with small group adverse selection issues. This is a phenomenon created by groups with higher than average costs enrolling in one plan. For this population, maintaining existing physician ties is most important, and they are most likely to continue their relationship through Blue Cross and Blue Shield's network. This selection bias ensures the overall small group population will usually be less healthy than the small group market in general.

Our problems in this rural market include a diminished ability to negotiate favorable rates for physician and hospital services because the provider is mostly likely the sole source of medical care in that community. In addition, niche players among the private, for-profit insurance industry have incentive to enter these markets with stringent small group underwriting.

Finally, Minnesota has dealt with the issue of uninsurable individuals with the development of the Minnesota Comprehensive Health Association, the Nation's largest statewide risk pool. This pool accepts all medically uninsurable applicants who apply today, and approximately two-thirds of its membership is from rural Minnesota.

Contributions to the cost overruns are calculated as a percentage of premium income. Therefore, Blue Cross and Blue Shield is the largest contributor.

Because of the ERISA preemption, self-insured employers, approximately 50 percent of the health care market in Minnesota, do not contribute to the pool losses.

Furthermore, Minnesota has the unique distinction of having more mandated benefits than any State save one. These mandates, again due to ERISA preemption, do not affect the larger self-insured companies.

In order to address these issues, Blue Cross and Blue Shield of Minnesota believe that a Federal minimum core benefit package should be established. Such approaches have already been implemented in Virginia and Washington.

With respect to the Pepper Commission recommendations, we commend your work and support several of the Commission's objectives. These are outlined in my written testimony.

I want to highlight our concern about the perception that open enrollment will solve the problem of access to health care coverage for small groups. We believe that the intent of open enrollment could be effectively achieved by requiring small group carriers to accept all groups applying for coverage, so long as there is some sort of reinsurance pooling mechanism to spread the costs of those individuals whose health risks are significantly higher than the agreed-upon average. Funding for this pooling mechanism would need to be equitable across all carriers writing small groups.

When carriers have to aggregate all their small groups and charge an average rate that is the same for every group, the community rate, those groups whose experience is better than average will know that they can purchase similar coverage with lower premiums from carriers who selective market to better-risk groups.

An alternative way of dealing with this issue would be to limit the now sometimes wide variations between the highest rates and the lowest rates for comparable coverage—what we call the rate spread. However, with both community rating and limiting the rate spread, it must be recognized that the rates of the younger, healthier groups will be forced up. It is imperative that caution be used so as not to create disincentives for groups remaining in the insured market.

Our ultimate challenge at Blue Cross and Blue Shield of Minnesota will be to devise ways of ensuring affordable care in a society challenged by miracles of medical technology, complexities of the graying population, and the never-ending demand for services on the part of the American public.

I would be happy to answer any questions.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Niemiec follows:]

PREPARED STATEMENT OF RICHARD NIEMIEC

Chairman Kennedy and members of the subcommittee. I appreciate the opportunity to testify before you today. My name is Richard Niemiec and I am Senior Vice President, Underwriting, Actuarial and Legal, for Blue Cross and Blue Shield of Minnesota.

We share your concern about the increasing number of Americans without health insurance and applaud the leadership role that you have taken on this difficult issue. I would like to give you a little background on Blue Cross and Blue Shield of Minnesota, go over briefly some general thoughts about the Pepper Commission proposal, and then address more specifically some concerns about the insurer standards included in the Commission proposal.

Background on Blue Cross and Blue Shield of Minnesota.

Since the early 1970's, Minnesota has been at the forefront of the evolution in changes in the health care industry. It has been both our pleasure and our challenge to operate in a highly competitive marketplace encompassing the entire spectrum of health coverage alternatives, from the most tightly structured staff model HMO to wide-open fee-for-service indemnity programs. It is within this context that I address my comments today, examining access to health coverage for the working uninsured as well as exploring methods to assure continued affordability of coverage to the currently insured population.

Blue Cross and Blue Shield of Minnesota has operated as a not-for-profit health services corporation for over 50 years. We are the largest writer of health care coverage in Minnesota currently servicing over 1,100,000 Minnesotans with a variety of coverage options designed to meet the needs of a particularly diverse and competitive marketplace. We do this through our managed care fee-for-service indemnity program and through the use of our affiliate HMO, Blue Plus.

Our coverage ranges from insured individual contracts for those both under and over age 65, to coverage for large corporate buyers looking for self-insured arrangements. In between, we have a number of program alternatives designed specifically for the smaller group market. This wide diversity in options and in enrollee populations mirrors our ongoing commitment to meet the health care needs of all segments of the population in an increasingly complex environment.

Lately, we have heard much about the "sickness" of the health insurance industry. Blue Cross and Blue Shield of Minnesota believes that this perception is due largely to the difficulty which insurers have had in offering programs suitable in both benefits and price for small employers. It may be helpful to put this difficulty into perspective by describing for you how Blue Cross and Blue Shield of Minnesota operates, the obstacles we confront and the successes we have enjoyed in our effort to address small employer group coverage needs.

Minnesota is dominated by the metropolitan twin Cities area of Minneapolis and St. Paul. Of its 4.4 million citizens, about 2.3 million live in the metropolitan Twin Cities. However, beyond the Twin Cities, Minnesota's population is spread throughout the state in a largely rural configuration. Blue Cross and Blue Shield of Minnesota insures about one fourth of the state's total population with the majority of coverage written for businesses and individuals located outside the metropolitan area.

The need to respond to an urban marketplace, where we have a smaller proportion of the market share, and rural settings where our coverages may be the only viable option, requires us to use creativity and flexibility in product design.

In the urban setting, our major competitors in both premium income and market share are HMO programs, coupled with nationally-based for-profit insurers for whom health care may be just one line of business, or whose coverage may be written in conjunction with a locally organized PPO. This is a formidable place to do business. Some of the issues with which we grapple include:

- Negotiating provider contracts, both institutional and physician-based, that allow premium levels to stay competitive with the other health plans.

- Developing case management strategies that assist in assuring appropriate care delivery within a network of providers which is large and which allows direct access.

- Dealing with small group adverse selection issues. This is the phenomenon created by groups with higher than average costs enrolling in one plan. This results from choices made by those who are older and less healthy. For this population, maintaining existing physician ties is most important and they are most likely to be able to continue these relationships through Blue Cross and Blue Shield's network. This selection bias ensures that our overall small group population will usually be somewhat less healthy than the small group market in general.

  A second result stemming from this is known as the "adverse selection spiral." This phenomenon occurs when rates which are pooled for all small groups are increased to reflect the costs of higher risk enrollees. Lower risk groups within the pool may then migrate to less expensive coverage from plans which manage not to take cross sections of the population. This assures the ultimate spiraling of premiums in the pool.

- HMOs which have relinquished Federal Qualification status in order to operate under less stringent state medical guidelines and to use experience-based rather than community-based rating approaches--which allows the HMO to consider the experience of a group in establishing its rates.

- For-profit insurance carriers operating in conjunction with PPO networks which severely limit provider availability, except at substantial additional cost. The medical underwriting restrictions of these carriers are usually more stringent than those of Blue Cross and Blue Shield of Minnesota, which limits their exposure to high risk groups within the small group market. Additionally, the overall fiscal status of these carriers is not solely dependent upon their health coverage business.

These are formidable challenges for Blue Cross and Blue Shield of Minnesota with multiple adverse results including: fragmented market share; the phenomenon of small groups moving frequently from carrier to carrier in order to capture the lowest premium rate; and groups with the sickest employees wanting to maintain existing physician relationships opting most often for the Blue Cross and Blue Shield of Minnesota open provider network. This makes the task of offering diverse coverage options extremely difficult while continuing to assure the sound financial health of this corporation.

And that is just the urban picture.

Blue Cross and Blue Shield of Minnesota is also faced with the challenges presented by the needs of the rural market where we are the predominant supplier of health care coverage. In this market, the issues are substantially different. Blue Cross and Blue Shield of Minnesota is faced with the need to supply small group coverage to a market which is made up of governmental entities like counties and school districts, or very small businesses and self-employed individuals, including farmers. This poses a number of market issues including:

- A much diminished ability to negotiate favorable rates for physician and hospital reimbursement because the provider is most likely the sole source of medical care in that community as well as the surrounding geographical region.
- Niche players among the private, for-profit insurance industry which have an incentive to enter these markets with stringent small group underwriting. Because of their underwriting, they can offer rates that are attractive to the healthiest small group purchasers who are able to pass medical underwriting requirements. Often times these carriers are also able to avoid expensive state mandated benefits through various ERISA preemptions, for example, they may be structured as a self-funded multiemployer trust.

Finally, it is important to describe state initiatives enacted in Minnesota. Minnesota has dealt with the issue of uninsurable individuals with the development of the Minnesota Comprehensive Health Association (MCHA), the nation's largest statewide risk pool. Administered by Blue Cross and Blue Shield of Minnesota, this pool accepts all medically uninsurable applicants who apply and today, approximately two-thirds of its membership is from rural Minnesota. Premiums for this program are set at statutorily defined maximums with cost overruns funded today only by the health insurance carriers and HMOs writing fully-insured coverage in the state.

Contributions to cost overruns are calculated as a percentage of premium income. This means that Blue Cross and Blue Shield of Minnesota is the largest contributor. Let me illustrate this by noting that our annual assessment from MCHA in 1990 for 1989 losses was $4.3 million on a total cost overrun for the program of over $20 million.

The inherent flaw in the MCHA program is the ERISA preemption which results in the inability of the state to include self-insured coverage in the calculation of the assessment for the losses of the program. This means that approximately 50% of the health care market in Minnesota does not contribute to the losses of the MCHA program. As more companies continue the rapid movement towards self-insurance, the funding mechanism for this risk pool continues to shrink. Consequently, the losses of the program are born only by the small group and individual market already struggling to afford health care coverage.

This predicament is highlighted by the recent failure of a self-insured business in rural Minnesota, employing approximately 1,200 people. After cancelling coverage and laying off employees, the public policy makers' response to the crisis is to use MCHA as the safety net to assure the continued availability of health care coverage for the employees and their dependents. The inappropriateness of using MCHA as the solution for the failure of a self-insured program is readily apparent because of the inequity which results from the ERISA preemption. The burden of this self-insured company's failure will be placed on small businesses and individuals in the state of Minnesota when the company has never contributed to MCHA.

Minnesota also has the unique distinction of having more mandated benefits than any state, save one. These mandates address coverage requirements, provider access and direct reimbursement of various provider types in our small group and individual programs. Again, due to ERISA preemption, these mandated benefits do not affect the larger self-insured companies. The wish to avoid mandated benefits fuels the desire to move to self-insurance and exacerbates the problems of funding the risk pool.

Blue Cross and Blue Shield of Minnesota believes that there are two viable approaches to the issue of equitable application of mandated benefit laws. The first is to eliminate the ERISA preemption and require all health care coverage, regardless of funding source to incorporate the state mandated benefits. The second, and we believe the more preferable approach, is to define at the federal level a "core" benefit package which must form the basis for any coverage made available. This core benefit concept would have as its objective a low-cost minimum package that would allow insurers to offer more affordable coverage, in particular, to small groups. Core benefit approaches have already been statutorily implemented in the states of Virginia and Washington in an effort to make coverage more affordable for small employers.

Pepper Commission Recommendations

We commend your work and the work of others on the Pepper Commission. We support several of the Commission's objectives including the proposals to:

- o Make insurance more available and affordable for small employers by providing tax credits and subsidies and by allowing self-employed individuals to deduct 100% of their premiums.
- o Develop and implement a comprehensive national system of quality assurance including practice guidelines.
- o Expand public financing for health care for people with incomes below 100% of Federal poverty levels and federal assistance on a sliding-scale basis for other low-income individuals.
- o Preempt State laws that require costly health benefits be included in all insurance products in order to offer an affordable health benefit package.

We do have two central concerns about the proposal in its fully phased-in form. We are very concerned about the significant cost implications, especially for small employers and employees of small businesses. In addition, while the proposal attempts to maintain the American private insurance system, we believe over time, the requirement for employers to provide insurance or pay taxes may evolve into a massive, federal program.

With respect to the Commission's proposals for insurance reform, we too are concerned about some of the insurer practices that have limited access and contributed to high costs for some small groups.

However, we are concerned by the perception that open enrollment will solve the problem of access to health coverage for small groups in either the urban or rural setting. Blue Cross and Blue Shield of Minnesota believes that the intent of open enrollment can be more effectively achieved by requiring small group carriers to accept all groups applying for coverage, so long as some type of reinsurance pool is established for those individuals whose health risks are significantly higher than an agreed upon average. Funding for this pooling mechanism would need to be equitable across all carriers writing small groups and designed to discourage noche players in the market.

We are also concerned with the frequent misperception that a community rating approach will assure greater access to insurance coverage. Blue Cross and Blue Shield of Minnesota believes this solution will not work given the complexities of today's market and the myriad changes in the health care coverage and delivery system which have occurred over the last 30 years. We are no longer the only game in town. The availability of many coverage options meets a market demand, but also results in fragmentation of the market and the inability to apply the law of large numbers, and spreading of risk within the portion of the community which we insure. When carriers have to aggregate all their small groups and charge an "average" rate that is the same for every group, those groups whose experience is better than average will know that they can purchase similar coverage with lower premiums from carriers who selectively market to better risk groups. Thus, the cross-subsidy of one better risk group supporting the premium needs of a less healthy group is lost.

Blue Cross and Blue Shield of Minnesota believes that there are changes which could be made to address these deficiencies without a major disruption to the many positive elements in today's health care system.

First, as I suggested earlier, Blue Cross and Blue Shield of Minnesota believes it is possible to require that health carriers accept all small groups if there is a reinsurance mechanism available available to redistribute, in an equitable way, the cost of those individuals whose health risks are significantly higher than an agreed upon average. Such a pool must be financed through an equitable funding mechanism. With this type of pooling mechanism available, Blue Cross and Blue Shield of Minnesota believes it is possible to better stabilize the rates within the small group market by limiting their divergence. However, it must be recognized that by limiting the spread of rates, the rates of the younger, healthier groups will be forced up. It is imperative that caution be used so as to not create disincentives for groups to retain their insurance coverage.

First, it will be necessary to define within this small group market, what constitutes inappropriate and unfair underwriting practices and develop appropriate regulatory oversight.

While minimizing rate divergence is an achievable goal, enough flexibility in rate design must be maintained to allow appropriate incentives for encouraging maintenance of healthy lifestyles. A single rate for all groups would remove the ability to place some responsibility for the cost of care back onto the individual and their lifestyle choices.

Second, in order for the pooling mechanism used to redistribute the cost of high-risk enrollees, it is necessary to assure an equitable funding base. With respect to small groups, this could mean a funding source of all health carriers writing small group coverage based on percentage of premium written in the small group market.

Risk pools such as MCHA for uninsurable individuals must diversify its funding base. This can only be done through the elimination of the ERISA preemption and the resulting inclusion of self-insured companies in the funding base.

These changes, thoughtfully implemented, address the issue of access to insurance coverage in the small group market. Our ultimate challenge will be to devise appropriate and ongoing methods of assuming affordable care in a society challenged by the miracles of medical technology, complexities of a graying population, and the never-ending demand for services on the part of American people.

I appreciate the opportunity to testify, I will be happy to answer any questions.

The **Chairman**. The estimates, Mr. Mueller, that have been before the Pepper Commission indicate that in excess of 90 percent of the members of the National Association of Manufacturers provide some form of health benefits.

Mr. **Mueller**. Yes. It is the high 90's, 96, 97.

The **Chairman**. Now, we have found in the Pepper Commission that employers who are providing benefits pay an estimated 15 percent surcharge because of the cross-payment for employers who do not provide benefits. Do the people you represent mind paying that, and do they think that is fair?

Mr. **Mueller**. They know it is part of doing business, if you will. Is it fair? They feel that there are other ways, which we address in our report and will give to you. But right now, it is part of what the cost is. Do we think it is fair? No—not across-the-board.

The **Chairman**. But your testimony is that even though they are paying this surcharge—and there have been recommendations about how it could be reduced as a business cost; the best estimate, as I said, and a fair one, is 15 percent by having some kind of a universal system—their position, at least as you are expressing it here today, is that they will continue to pay that.

Mr. **Mueller**. Pay a tax, yes, but maybe not that amount.

The **Chairman**. Well, what is their estimate?

Mr. **Mueller**. We haven't finished up all of our studies yet.

The **Chairman**. Well, it has been going on for some time; the NAM has been appearing before my committee for 20-odd years, and I ask you the same questions most of the time, and they are pretty predictable.

Mr. **Mueller**. Yes.

The **Chairman**. Now, effectively, the manufacturing sector is subsidizing other sectors in our economy, like retail sales which does not face foreign competition. What do you think ought to be done in terms of the retail sales industry generally?

Mr. **Mueller**. Well, I think it is a matter of the issue of exposure or risk of the people being covered, if that is more your question. The retail sales industry has a different risk profile than we do in manufacturing.

Yes, we are carrying part of the burden, being manufacturers, against global competition, anywhere from the GNP percent to the taxes to the requirements that we're talking about here. I'm not here today we are going to pit one industry against the other, but I'm saying that all of business, be it retail service or manufacturing, we in the manufacturing element do oppose the mandating of benefits. We'd rather have the markets open up and have products available so that businesses can afford to provide coverage, number one; and number two is that, as we have already heard today, even if people have access to coverage—we have very fine coverage for our associates, that is both economical as well as effective—but they cannot get good treatment or access to treatment in the major metropolitan areas, let alone the 126 other cities we are in.

So we share that concern greatly with you. We need to see more distribution and more reallocation of resources throughout our country. I've got associates in major community that are having a hard time getting adequate or appropriate care.

The **Chairman**. Well, if you are not for the mandated program, I imagine you would be for some kind of public program?

Mr. **Mueller**. That is part of it. But also, like we said, we support the initiatives for the small business insurance groups. We think that many of our associates in business will buy it if they can afford the coverage.

For example, in underwriting, where small businesses will be charged a loss ratio of 70 or 75 percent, or 70 cents on the dollar that they pay in premiums, where does the remaining 30–35 cents go?

The **Chairman**. Well, how much subsidy does the NAM support? Subsidy is just another way of saying Federal payments, but how much does the NAM support?

Mr. **Mueller**. I'm not able to comment on that on behalf of the NAM right now, Senator.

The **Chairman**. Well, I'm just trying to figure out where you are on it, because you are not for a mandated system——

Mr. **Mueller**. No.

The **Chairman**. [continuing]. But some sort of a public system that will be subsidized——

Mr. **Mueller**. Yes, we——

The **Chairman**. [continuing]. Wait a minute, if I could just understand. And you demonstrate some concern about the quality, even if they do. Now, how much is the NAM prepared to subsidize the industry?

Mr. **Mueller**. If you are looking for a percentage, I am unable to give that to you.

The **Chairman**. Just amounts in broad figures. You know, the Pepper Commission is criticized for not coming up with numbers in terms of what the cost is going to be. And I think that criticism is implicit in terms of your own observations, and I am asking you what figures the NAM is prepared to come up with.

Mr. **Mueller**. I think that we will come to you and say that we will pick up our fair share as long as it is spread across all sectors.

The **Chairman**. Well, what are you talking about in figures?

Mr. **Mueller**. Ten, fifteen, like you talked about.

The **Chairman**. What, 10 or 15 billion?

Mr. **Mueller**. Sure.

The **Chairman**. Where are you going to get that from?

Mr. **Mueller**. We, ourselves, in business?

The **Chairman**. No. The NAM is prepared to support $10 or $15 billion a year in subsidies for business in this area; is that correct?

Mr. **Mueller**. For all businesses, right.

The **Chairman**. Yes. Where are you going to get that money from?

Mr. **Mueller**. We will have to get it either from our economies or our efficiencies of operation.

The **Chairman**. Well, I thought you were talking about the subsidies, $10 or $15 billion in subsidies.

Mr. **Mueller**. Right.

The **Chairman**. That's going to come from the Federal Government, isn't it? Isn't that what you are talking about when you are talking about subsidies?

Mr. **Mueller**. Well, I misunderstood the term "subsidy". I'm talking about ones that we will support by our payment or payment of additional charges; we will go along with some of that.

As far as the payment by the Federal Government, we think that they are also an equal partner there. We don't believe that all $66 billion is the responsibility of the Federal Government, nor do we feel that it is all the responsibility of business. We believe that all of our sectors have a part to play in this.

So if you want to know an exact percentage, I'll be happy to get back to you within a month, when the final report that we have will be issued.

The **Chairman**. I'll ask Karen Davis, how realistic is that approach?

Dr. Davis. Well, I think the Pepper plan does have quite substantial subsidies for small business. If they purchase private insurance, it would pick up 40 percent of the premium for them.

I am still somewhat skeptical that we are going to get good coverage voluntarily even with those subsidies. But I think the option of letting small business buy into a Medicare-type public plan by just making a payroll tax contribution, and then the employer knows what they are going to pay—it is predictable—you've got 5 percent of payroll or whatever it is set at, and you've got a predictable cost, and costs are controlled because they are in a Medicare-type system, which has tight provider payment plans.

But when small business says they cannot afford this coverage, I think we've got to look at how much the workers of small business can afford this coverage, because if it is not provided, and they are uninsured and they get sick, then it is up to them to pay their bills, and they are in even a less favorable position for paying these bills.

So I think just giving subsidies is not going to be enough. We are really going to have to move toward getting public coverage or mandatory coverage if we are really going to provide financial protection for these workers.

The **Chairman**. Senator Durenberger.

Senator **Durenberger**. Mr. Chairman, on the subject of the subsidy, I must say, sitting on the Finance Committee and watching George Bush's lips, which is getting to be a tiresome thing to do, one of my concerns for the Commission's recommendation with regard to small business is how much are we willing to pay and from what source.

Currently—and my staff gave me these figures—the tax subsidy for employer-paid health insurance premiums is about 40 percent of premium with current rates, and this is averaged out. So I was going to ask Bruce, for example, what your premium costs are at Motorola, where you provide good coverage for all of your employees. But let's say you've got a $400 per month premium; $160 of that is coming from the rest of the taxpayers in this country in revenue foregone.

My staff also figured out the Commission's recommendation with regard to the small business subsidy, which would add additional subsidies on top of the current premium subsidy, it would be about a 72-percent subsidy for the cost of the premium.

So I think the same question we have to ask with regard to those subsidies, and the question I'd like to ask the employer representatives here today is, philosophically, how do you feel about taxpayers subsidizing your premium contributions, which are in lieu of cash wage payment? How do you feel about the taxpayers across-the-board providing a tax subsidy for all of this health insurance—philosophically? The NAM, or Southern California Edison, or whatever and I don't think we need a study for this one, Bruce—at what level do you think there should be a tax subsidy from all of the poor people and all of the rich people in America. This includes every, single working person in America who has got a job, who is getting paid, has a variety of fringe benefits, a variety of other things, and in addition to that, currently has a 40 percent tax subsidy under every month's purchase of health care? Whether they need the health care or not, they get this subsidy. Philosophically, do you think that should be 30 percent? Fifty percent? One hundred percent? What should it be? Do either of you have any thoughts?

Ms. DECKER. Well, I think that you have to step back and ask what are we trying to provide. And health care benefits, I think, are a right of each person in America.

Senator DURENBERGER. Really? Why don't you explain that.

Ms. DECKER. When you look at the ability to live in America and work in America, I think you have to have some way to be able to obtain health care. And the reality of our system is that you can't obtain health benefits unless you are one of the very privileged few, unless you have a health benefit program that is helping you to pay for those services.

So looking at the broader perspective, I think it makes sense that there is a subsidy—this indirect subsidy that you are talking about—on premiums because we believe in the group insurance principle. If I have cancer of my lungs, and it is going to cost me $200,000 to get treatment, and the person next to me is perfectly physically well and needs nothing, are we ready to say that because I have assets of only $100,000 that I do not get treatment?

I think the principle of group insurance that we have all agreed to historically has to operate here, and we spread the risk, and I think we also need to spread the costs even through these back door subsidies on premiums.

Senator DURENBERGER. I'm trying to get back to the subsidy issue, which gets us to the right, and I am glad you mentioned that. I have always thought that the right in a society like ours is to have doctors and hospitals and health advice and people like Dick Niemiec, who stay healthy every day—he is going to run in the Boston Marathon, Mr. Chairman, next week—to have these kinds of things available.

I don't see anywhere in America there is a right to group health insurance. I don't see anywhere in America there is a right when you go to work to have health insurance. What the right is is that they pay you for your services, that you are compensated by your employer for the value that you add to the goods and services. And I think the right in this society, and our job, is to make sure that we have the best medical services in the world, the best drugs, and all the rest of that sort of thing.

Where is the right to health insurance?

The **Chairman**. Well, we have very able witnesses who can speak for themselves. But I take a Pledge of Allegiance— which was debated during the last Presidential campaign—and it talks about "liberty and justice", and this country talks about a commitment to "liberty and justice"—but how can you have a just society that is structured in such a way that my son, who had cancer, will never be able to get coverage again in this country because of the private insurance industry? Justice. I mean, we are not saying that written in the Constitution is "national health insurance", but it is justice. And if you are talking about a just society, and health is the most basic and fundamental of all, how can you have a just society unless you are going to deal with it?

You know, we can go around on this for a long time, and others can speak for themselves about it, but it was hanging out there, and I thought I'd take a stab at it.

Karen, do you want to take a bite out of this apple?

Dr. Davis. Well, I do think we were founded on the principles of life, liberty and the pursuit of happiness, and that is more than just having a hospital down the block; it is more than just having a physician there. If we are really committed to assuring in this Nation that no person dies because of an inability to pay for health care, then we can't have the kind of system that we have. We really have to have universal health insurance coverage, and somebody has to pay for it. Your point is well-taken. Business doesn't want to pay for it. Do they want to pay taxes, to have subsidies, to encourage them to do it voluntarily?

But we've got to pay for it because we are not living up to what any decent, civilized society should do and what every other major industrialized Nation does if we don't provide some basic floor of uniform insurance coverage.

Senator **Durenberger**. I don't have a problem with that, and I don't have a problem with what the chairman just said. But the chairman used a very good example of his son, which is not only high-cost medical care, but the inability to ever get insurance, or whatever it is in the current system.

And Barbara used the example of $200,000 worth of cancer. I can't argue that. I would insist that we have a right to financial access to these systems. All I am asking is why do the taxpayers have to buy a $90,000-a-year Senator his glasses, when everybody in America is eventually going to be visually impaired? Where is the right to subsidize my glasses, my toothbrushes, all the rest of this sort of thing? That is what has happened to insurance in America. It isn't insurance. If it were insurance, we should make sure on the basis of income—some people need insurance to get their glasses; I don't. That is the question I am trying to raise with regard to the degree of subsidy.

There is no question that society owes everyone the financial wherewithal to get to the doctors and the hospitals and so forth. My question just gets back to the chairman's, which is how do we put the subsidies in place, for what level of access, for what kind of people.

The **Chairman**. Mr. Niemiec?

Mr. **Niemiec**. Thank you, Mr. Chairman.

I'd like to respond to the Minnesota situation, which I know best. In Minnesota, Senator, your son would be able to get coverage right now. I mentioned the Comprehensive Health Association. Not everyone is paying into it, but we have a program that works. We've got 18,000 people in our State in that. It is a little bit higher cost than you get on the private market, but it is subsidized.

The CHAIRMAN. Does it take all pre-existing conditions?

Mr. NIEMIEC. There is a pre-existing waiting period, but the reason for that is so that someone does not buy the coverage on the way to the hospital. So that is a problem if there is not coverage before that. But once you are in the program, you would never be canceled. We at Blue Cross and Blue Shield do not cancel people.

As I was describing what we would like to see happen with the small group market is to develop a reinsurance pool mechanism so that all groups could be accepted. Then if your son worked for a small employer who had trouble getting coverage, underwriting, that would no longer be the case, and we would like to see limiting the spread of rates on that.

So I think in Minnesota, you can see that we've got a laboratory there where a lot of things have worked well. We invite you to look at what has happened there. We take cost containment very seriously.

There were comments earlier about practice patterns. We are working with Dr. Chasen, who was mentioned earlier, to do these practice standards. In fact, what is happening is an awful lot of the doctors and hospitals are pretty mad at us, because they feel we are looking over their shoulders. Unfortunately, sometimes our members aren't happy if we make a decision where they feel care is necessary and we don't feel it is appropriate.

So that I think in Minnesota we've gotten to a place where we've got about half a dozen responsible, large enough health plans to do it, and what we compete on right now is quality and the ability to contain cost as well as try to extend the coverage. But we can only do our part. There certainly is a governmental role in that.

The CHAIRMAN. I would take note that we have been out to Minnesota and had hearings on health care when we were doing our HMO legislation years ago.

What would it cost, for example, for two 50 year-olds? What would they pay in premium in Minnesota if they had some pre-existing condition?

Mr. NIEMIEC. For an individual it would probably be well over $200, so you'd be talking about $300, $400.

The CHAIRMAN. Thank you.

Dave?

Senator DURENBERGER. I think the answer is that nobody is really sure where that subsidy level ought to be. Kathy just gave me the figures on Medicaid, and we have $29 billion in Federal aid currently going into Medicaid for about 23 million eligible recipients. That works out to $1,260 per year per individual, or $105 per month. If you remember the example I used of the hypothetical Motorola $400 premium, 40 percent subsidy, there is $160 for the President of Motorola and $105 for Medicaid.

That's the part of the issue I was trying to get at, not that the poor don't have a right to get into the system, but that if we are spending $160—and that's an uncontrolled subsidy; the more you spend the higher the subsidy goes—if we are willing to do that as a society, why can't we get our willingness up for low-income people and come up with the answer to the question the chairman asked?

Mr. **Mueller**. Well, I think, Senator, to correct one misperception, our cost is not $400 per employee; it is about $223 per employee per month on average.

The **Chairman**. Senator Rockefeller?

Senator **Rockefeller**. Thank you, Mr. Chairman.

Mr. Mueller, HCFA says, according to Barbara's testimony, that the total compensation for employer health care expenses has now gone from 9 percent to 50 percent of pre-tax corporate profit.

Mr. **Mueller**. Fifty?

Senator **Rockefeller**. Five-zero. That is quite a lot of money of pre-tax profit.

Mr. **Mueller**. That's correct.

Senator **Rockefeller**. What so fascinates me about the National Association of Manufacturers and business is that what the Pepper Commission and others are doing here is so totally in your interest.

Barbara, you made this wonderful statement, and all of a sudden you snuck in a little thing at the end, and you said, "Oh, but"—and I don't even know if you meant it or if you knew you said it—you said, "Oh, but we have to do all these other things, cost containment, before we do access." And you were praising the Pepper plan and doing all this, and then you just snuck that in there very quietly.

Here, Bruce, the Pepper Commission is laying out for most of the people who don't have insurance, small business, and you indicate yourself that 96 percent of small business offer benefits now—that's an NAM figure—94 percent offer dependent coverage—that is an NAM figure—and then you say, of course, mandates will kill the goose that lays the golden egg. Healthy employees are tremendously important to America's competitive position.

Mr. **Mueller**. Correct.

Senator **Rockefeller**. And then NAM says that Pepper Commission mandates, etc., would diminish international competitiveness. And you and I know perfectly well that those who are doing business on an international basis all have health coverage, and Motorola being obviously one example of that. I mean, it is a totally specious argument.

We offer 40 percent tax credits on premiums to small business. We say that if they don't want to pick up the cost of this, they don't have to do anything for five years, five years from date of enactment. Five years. Nobody has ever said that. And then we say if you are self-employed, which a lot of people are, 100 percent deductibility. If you are unincorporated, 100 percent deductibility. Nobody has ever said that.

Now, NAM does not have a plan. NAM doesn't like mandates. Business doesn't like mandates. This is not mandates in the classic sense. This is mandates with every, single inducement, seduction, bribery for small business, and small business in fact, in spite of what Karen Davis says, I think will in fact be able to afford this, particularly as it is done over a period of five years.

So you come along, and you say all of these good things about the things that you want to see happen, and then you say, "But I'm sorry, the mandates, we just can't accept that." And as soon as you say that, you throw everything else out. You know perfectly well that unless there is a trigger which leads to a mandate that you will not get universal access to health care, and you will not have universal health insurance. You know that intellectually, spiritually, anywhere inside of you; you know that is true, and yet you reject it. It is an ideological position. It is not what you really think, and it is not what NAM really thinks.

As the chairman of the committee has indicated, it is a position that business has that it has itself so wedded to that even Barbara, who is doing this incredible number on progressive health care, had to slip that thing in—which then vitiates the entire Pepper Commission. So you are actually coming out against everything that the Pepper Commission is for, even though what we are trying to do is offer a healthy work force to America, literally seduce them into being able to afford it, and you say, "I am sorry, we simply cannot buy mandates," knowing full well as you say that that you reject the entire position.

Now, tell me what is responsible about that? And then, you have no alternative—you don't want national health insurance—you have no alternative to offer. What is responsible about your position? Why can't you simply say that this is something different than mandate, that the Pepper Commission has come up with a very unique, never-before-done approach which makes it possible for those who cannot afford it to be able to afford it, and that indeed we are doing all the things—insurance reform, outcomes research, liability, and all of that is going to be put in place—but you can't wait for all of that to be put in place before you do that, because you insure your own people, and you do it for a reason, because you want them to be productive, you want them if they have a sick child not to have their minds distracted as they are doing the work of Motorola on cellular paging devices. You want healthy employees, and you want healthy employee dependents. You do that for a reason. You want everybody to do that for a reason if you want America to be competitive.

So what are you really telling us?

Mr. **Mueller**. I think you've asked me a lot of questions.

Senator **Rockefeller**. Basically just one.

Mr. **Mueller**. Why do we oppose mandates?

Senator **Rockefeller**. Yes.

Mr. **Mueller**. I think we oppose mandates because in the essence of what we do or how we compete, we need flexibility.

As our testimony says, we are not against access. We are not against employers being encouraged to get tobacco coverage; that is appropriate. But when you talk about the standpoint of global competitiveness, we do pay more than our competition does. I am talking about the Asia Pact countries that we deal with versus the United States.

We look at the fact that to mandate, to tell somebody that they must have this and not have the products or the delivery mechanism available or to the point that to have coverage means something—we think it is an integrated function. Just to say we are going to mandate you to have coverage, where our associates in the insurance industry or in government don't allow an affordable product, is one issue. But to have——

Senator **Rockefeller**. Not with the Pepper Commission, it is not an issue.

Mr. **Mueller**. No, I'm talking about in general, Senator. In our testimony, it says we do agree with you on the topic.

We are also talking about——

Senator **Rockefeller**. I didn't understand your last sentence.

Mr. **Mueller**. When you said it is not an issue in the Pepper Commission, we are not disagreeing with you on that topic. We are talking about the pure mandating of benefits. We don't agree with that, nor will we. I understand how you feel that we are against something that you say, well, gee, it is against motherhood and apple pie. It is really more than that. It is the ability to make a decision; it is the ability to get a product, to have something available.

If you are also saying that we are going to mandate having all of these products available for the marketplace—but do we really know the impact? Do we know what access means? Access to what?

Senator **Rockefeller**. You want a perfect world.

Mr. **Mueller**. No, we don't.

Senator **Rockefeller**. You want a perfect world.

Mr. **Mueller**. We want a better world than what we have right now. What we are saying is that access isn't the only key issue. It is the availability and the cost responsibility of all parties concerned.

Senator **Rockefeller**. And what you are saying, Bruce, is that you want the world to have an integrated health care system all perfectly in place, classically beautiful, architecturally wonderful, before business has to say—and so much of it being such a tiny proportion of business that we are talking about—before business should be required——

Mr. **Mueller**. I don't think we will ever get to the point where we will agree that business should be required. We're not saying a perfect world, Senator. What we are saying here is we think it has got to be an integrated function of all three abilities—cost, access and quality—that we need together. Just to open up the door and say everybody has access to a system—a system of what?

I come from an area where the physicians are paid 40 percent of the national average when they have a white-collar strike going on. We're not talking about a perfect world, Senator. What we are talking about is a three-pronged approach. We don't agreed that mandating will cure nor take care of the other issues, either.

Senator **Rockefeller**. What about if we do both at the same time?

Mr. **Mueller**. What we are suggesting in our report is that we take all three areas——

Senator **Rockefeller**. Answer my question. What do you think if we do both at the same time? What is wrong with that? Are you willing to take that risk?

Mr. **Mueller**. When you say do both, you mean mandating and what?

Senator ROCKEFELLER. And making as good an architecture in the health care system, insurance reform, and all the rest of it, medical liability.

Mr. MUELLER. Do you include quality in that?

Senator ROCKEFELLER. Of course.

Mr. MUELLER. Well, then we have a three-headed approach. We think that that is appropriate.

Senator ROCKEFELLER. Then you would buy mandates along with that?

Mr. MUELLER. I still don't buy mandates in total.

The CHAIRMAN. Let me ask you, are you against the minimum wage? That's a mandate.

Mr. MUELLER. We're talking about the total compensation standpoint. May I answer a question with a question? Is that appropriate?

The CHAIRMAN. Please.

Mr. MUELLER. OK. When we at business look at benefits, we are looking from the total compensation standpoint, which includes compensation and benefit programs, not separately. So when there is an increase in minimum wage, we have to look at the impact on our employment base and our total labor cost.

The CHAIRMAN. Well, the point I was trying to pick up—you said you were against mandating. We mandate minimum wages. I'm just asking you, completely consistent with your position, are you against the minimum wage, because you are against mandating?

Mr. MUELLER. We are against mandates, yes.

The CHAIRMAN. You are against the minimum wage; that is mandated. Are you against occupational health and safety? That is mandated. We have mandated that you are to provide that. Are you against those?

Mr. MUELLER. We are against the principle of mandating, not the purposes we are trying to strive for, sir. And that is what we have said in our testimony.

Senator ROCKEFELLER. Then, don't you think it is in your interest to sort of get a little less hung up on principles and get a little bit more concentrating on what actually helps America's business, what makes a productive work force?

Mr. MUELLER. That's correct.

Senator ROCKEFELLER. I mean, I think you've hit it on the head. It is your principle. But your principle and your practicality are not in touch. Your principle is comforting. You can belong to the NAM, and you are in that good, collegial thing of we don't want mandates, but you've got unemployment compensation—you have no choice on that—are you against having to pay for unemployment compensation, Bruce? You are for it. I don't think you believe what you are saying. I mean, that's really what I'm trying to say.

I think it is so ingrained in American business that any word "mandate", even when it is put in the context that we almost invite small business into joining—do you know we had some small business groups endorse our report?

Mr. MUELLER. Sure. I wish, Senator, you would not portray my feelings.

Senator ROCKEFELLER. I apologize. I do apologize for that.

Mr. MUELLER. Thank you.

We have some small business associates in our organization, too, who support it. We also have ones who don't. The vast majority at the present time do not support mandating.

We believe that we have to get down to the basic issues of health care. We are not disagreeing with you on that.

Senator **Rockefeller**. You know, if we were to change the word—Senator Kennedy, we went through a wonderful exercise last year with the American Medical Association on physician payment reform, and I always knew when I was meeting with Dr. Samon because there would always be a full-page advertisement in the Washington Post the day that he and I were going to meet to negotiate. It showed a sad-faced woman, looking out the window, saying, "They are trying to turn me into an expenditure target." So I always knew he was going to show up for the appointment.

So what we finally did in effect, really—and Bill Gradison confirmed this—was we said, well, let's just stop using the words "expenditure target", and let's make up another word. And by golly, we did that. And Karen Polis behind me and I sat down, and we came up with something called "Medicare volume performance standard". And all of a sudden, the pressure was off.

Can we think of another word that would you improve your own competitiveness in the worldwide situation?

Mr. **Mueller**. Senator, I think when we submit our report to you later on this quarter, you will see some of that in there. I do recommend that you read that.

Senator **Rockefeller**. Thank you, Mr. Chairman.

Ms. **Cronin**. Can I jump in here? I think to the question would America's business consider the mandate if you did something substantive on cost at the same time, I think you would get more support.

Senator **Rockefeller**. Yes, because that is what you were saying during your testimony, which is why I didn't say anything about you, because you are part of that split personality——

The **Chairman**. I'm going to say a good word about Barbara, too. [Laughter.]

Ms. **Cronin**. I guess my feeling at this point is that, at least within the large business community—and I said this in my testimony—there are a lot of open minds, and the biggest issue is really cost. But if you can really come up with some substantive proposals in that area, I think it would get more consideration.

Senator **Rockefeller**. Thank you, Carol.

The **Chairman**. The only trouble I have with that is we tried to provide universal access with a Federal program 25 years ago, and they said, you can't do that because it is a big, new Federal spending program, so we've got to come up with a different alternative. Then we tried to mandate that the States do it—any way you want to do it, and any way the States want to fund it, just meet these standards. And, after 5 years—the response is you can't do that, that's the not the right program.

So now we have come up with this program with mandating because we haven't got any funds, but you can't do that because that is mandating business.

And then Senator Rockefeller comes up with a different way of trying to do it, in a different shape and form to reach that objective. It is balanced in terms of what business is going to do, what the States are going to do, what the Federal Government is going to do. It has an approach that I would favor, which is saying that now we don't have the resources, but we can take care of two-thirds of the uninsured through the private program. It is a cost of doing business. That is a different way, but no—that's not the right way.

In 25 years, except in terms of development of risk pools and some other little bits along the edges, we just haven't seen significant progress. We have not seen it. That is why I think, quite frankly, the encouraging factor is that this panel here understands that we do have a crisis, and really, we are going to have to address this, and now is the time to do it because unlike when we were talking about a national program 25 years ago, when the total number of insured was actually getting reduced, now it is expanding. And if you look at where the job openings are going to be over the next 20 years, they are going to be in those areas where they have no insurance, so the crisis is going to get even worse, particularly with women going into the work force and all the other kinds of changes.

So I think the encouraging factor of this meeting, even though we have obviously had some differences, is that people understand that we are really going to have to do something now, and hopefully with the good will and openness of the various interests, we will be able to move down that road.

Senator Durenberger.

Senator **Durenberger**. If the chairman would permit one more round of questions, I would like to make an observation about the mandate issue. I know that Jay feels these things very strongly, and I think the NAM feels very strongly, too. I am never quite sure whether it is expressed—it is sort of like messages going by like this as I listen to the two of you.

The examples of mandates that I heard from the chairman and my friend from West Virginia, I can understand. Those are mandates that relate to the exchange that a person makes when he offers himself to help somebody else as a worker, to provide a good or a service. And you mandate a certain level of compensation as a living wage. You mandate child labor to protect the health and the safety of kids. You mandate occupational health and safety so that people don't have to expose themselves to unknown risks in the workplace. We even mandate workers' compensation coverage across this country, or at least most States mandate workers' compensation coverage, for injuries and diseases incurred because of work.

The issue here is, do we want to take this fairly large leap forward to mandating a practice that employers began in one of your cases in 1903, to do for employees—not in the workplace, but at home—what they wouldn't do with the pay that you give them.

Would they buy adequate preventive health care for a new mom? Would they provide preventive dentistry for their kids? And the answer was coming back that, no, they wouldn't do it. So one of the things that employers in America decided to do was do it for them—create health insurance, Blue Cross, Blue Shield, whatever, so that we could have adequate doctors and hospitals and so forth.

Now we are going to do for them something they wouldn't do for themselves. They won't go and buy their own insurance, so we'll do it for them.

The chairman and the chairman believe, because it is good for these employees and because it is a way to guarantee access to everybody in this country, that we should add that mandate to the traditional work- and workplace-related mandates.

I hope that is a distinction that has a difference and that maybe at some point in time, I will agree with my two colleagues for whom I have so much respect already that it is important to add that mandate. Right now, I do not. I do not because I cannot get the employers to give up this huge subsidy.

I see all of these poor people out here who can't get into the doctors and the hospitals. I see us underfunding Medicaid—I gave you that $105 per month figure—you know, the actual costs for those people are probably closer to $200 per month, because if you go and look at what they are being paid under the medical assistance payments, the doctors and the hospitals are not getting paid what they are supposed to get paid under that system. So it is probably actually $200 per month.

But you know, I can't get Iaccoca to give up a $500 per month subsidy so that a little of that maybe can get used to help somebody else. And I can't find enough of my constituents willing to raise $500 for everybody so that all 242 million people can get into the system, because it is already 12 percent of GNP, and where is the money going to come from—George's lips don't move, and so on and so on.

So I don't want to keep coming back to the subsidy question except I think the chairman appropriately asked it. You are not going to reduce the expenses so you are going to have to help people get into the system. And with the exception of the top one percent, all the rest of the people are going to need a subsidy. We are going to have to keep some subsidy under the employer/employee access. We are going to have to keep it for the moms and the kids, which is the tremendous thing that this Commission did, pointing out the moms and kids problem. We are going to have to keep it there for the elderly and so forth. The question is to what degree. Are we going to relate it to income or health status or something else?

I think the NAM and everybody else could do us all a big favor if they responded to the questions raised by my two colleagues in that kind of a sense—not to say we are against mandates or we are against this or against that, but we are willing to accept some kind of a national policy which requires us to add to the other things that we are adding this health system, providing there is such-and-such a subsidy or whatever.

There are other issues that I would love to talk about in terms of insurance and so forth, and if I might, Mr. Chairman, there is one question I'd like to ask Karen and Carol in particular.

One of the things I liked about the direction the Commission went was in the direction of greater use of social insurance. In other words, you could see in this whole thing a national commitment to financing access. This bifurcated system where the States do some of it, the employers do some of it in their health insurance, and the hospitals and the doctors have to do some of it—we say that is not healthy, and so we move in the direction of using the social insurance system to undergird access both to medical services and long-term care services.

I am curious about your reaction to that as a policy direction in which the chairmen of both of these committees have led us.

Second, I think one of you spoke to the issue of reforming the delivery system, and I'd like to hear your reactions to that because most of us, particularly those of us on the Finance Committee, have spent a lot of our time trying to reform the delivery system by reforming the payment system. I, for one, am coming to the conclusion we aren't going to make it that way, that we've really got to go into the delivery system and find some way to change that—or maybe do both.

Karen.

Dr. Davis. Well, I think those are both good points. I do think that many of the recommendations of the Pepper Commission move us more in the direction of social insurance,certainly the recommendations that would Federalize Medicaid, cut the link with welfare so it would be an entitlement based upon income, that anyone below the Federal poverty level would be automatically covered with no financial barrier to care, subsidies for people up to 200 percent of the poverty level.

I think that the option of employers paying a payroll tax and getting their employees covered under a public plan is also in the tradition of social insurance. So I think that is very good.

I am a little bit less optimistic that we will ever go a total social insurance approach just because of our history. In 1950, the private health insurance industry was a $1 billion industry. Today it is a $150 billion industry. Today 75 percent of workers do get health coverage from employers. And I think because of that history, it is very difficult to either eliminate job-based health insurance, or it is inequitable to say most employers do it—even most small businesses do it—I was struck by the Pepper findings that 78 percent of firms between 10 and 24 employees provide health insurance to their workers; 46 percent of firms with fewer than 10 employees provide health insurance to their workers. I am surprised that those business who are doing it don't jump out and grab the Pepper plan, which would also provide financial relief to them and what they are already doing.

So we've gone in that direction. So say we are not going to have that, and either through tax credits or an expanded public plan, you are talking about shifting $150 billion from the private sector through, one way or another, to the public sector, just doesn't sound feasible to me.

So I think that the very pragmatic approach that the Pepper Commission has put forward of a merged public-private plan is a good model for us. A number of countries do that—Germany and others have this system of employment-based, but within the context of a social insurance, Federal standards, payroll tax contribution kind of approach.

So I think it has a lot of good elements that move us in that direction. I think what we need to do is make the employment-based insurance more equitable, with everyone contributing, and that we need to continue to move in that direction.

In terms of your comments about reforming the delivery system, I personally would give a little more weight than you seem to give to reforming provider payment. I do think that the experience of other countries, where they have had a strong government role in negotiating physician fees, such as again, the West German system of having—they don't call them volume performance standards there—expenditure ceilings tied into their physician payment has been very effective at slowing increases in health expenditures for physician services. So I think it is a very important innovation, and we have moved in that, and the idea of extending it to more and more people and encouraging private insurance plans to do it is good.

I do think that some of the recommendations on reforming the delivery system, though, are quite commendable and haven't gotten much attention—giving managed care options even to workers in small firms; making sure that people have a choice of going into health maintenance organizations is good; the kinds of support for the national health services corps, for the development of primary care, and even changing the fee schedule to increase payment for primary care and preventive services under the resource-based relative value system, I think again reinforces the need to rebalance our health system toward greater emphasis on prevention and primary care.

So I think many of the recommendations that are in there on reforming the delivery system are also quite worthy in and of themselves.

Ms. **CRONIN**. I would comment in terms of the first issue of the public plan that we are very committed to the notion of the national uniform standard, and also I think increasingly employers recognize that we've got to do something about Medicaid reimbursement rates.

At this point, I don't think we have a position yet on whether it should be a new public program, kind of complete start over, or whether it should continue at the State level through Medicaid.

I think we can argue pros and cons to both sides. We certainly agree that breaking the link to welfare would be essential in either case. But at this point, we don't really know. I think we have to discuss that further.

On the issue of the health care reform, delivery system reform, I wish I could be more specific here, and I think we are really going to attempt to push our folks on this because, as I said in my written testimony, a lot of the employers that belong to the Business Group are the ones that have been leading implementors of various cost management strategies. And I have to tell you that they are not really happy about where they are. And I think in fact, as Barbara said, that is why they have decided they need to work in a bigger forum at the State and national level, because they can't just buy products off the shelf that are going to solve the problem.

I think in essence one of the components is the need to really do something about quality, to really operationalize the notion of quality. You have spoken very eloquently about that this morning. We need to change the way physicians practice, and I think physicians understand that as well.

But I think we also need to know more about how to actually organize physicians, maybe move them away from being independent solo practitioners into group practices. We need to look again at our technology procedures, because there is a real sense that technology is also contributing substantially to our costs. It may mean that at some point in the future we have to limit employee choice. That is something that increasingly, employers are willing to do and potentially take the risks in employee relations. But it may mean that individuals can't go to any doctor that they want.

So we are really interested in being able to be more specific in answering this question, and we will share that information with you.

The CHAIRMAN. Thank you.

Mr. Niemiec?

Mr. NIEMIEC. I wonder, Mr. Chairman, if I could make just one more remark.

As I mentioned, more and more we are competing in Minnesota on how we delivery the care. And I think the things that we are doing, hopefully, are transportable to other employers, and other State and Federal programs, and things like that.

But the one comment I want to make is I don't think we have talked enough about the level of benefits. There is sort of the idea that one size fits all. Just to relate an experience that Senator Durenberger knows very well, in rural Minnesota, the predominant coverage of the farmers out there, the small business, has $1,000 deductibles, even $2,000 deductibles. Now, you might say that's a real problem, that people are not going to be able to go in and get the preventive care. But what we find from talking to these people is that that maybe is not the best alternative for them, and they probably would love to have first-dollar coverage like a lot of us have, but it works for them. If they end up in the hospital, they've got that catastrophic coverage. But what happens is they are also looking at what benefits they use; there isn't the urge to run in and get the eyeglasses and all those things. So that is something that has worked in that part of the State.

In the inner city of Minneapolis and St. Paul, alternatives like that certainly wouldn't work for a large share of our population. But they have the flexibility to offer different benefits geared to different populations. But the big problem we've got is with the ERISA preemption. ERISA, with mandated benefits and so on, we just cannot do that, we cannot come down that core. That is where we need some help, and I think if we could get to a core and see how it works, then we'd have to judge. If care is still not being delivered, if you have some coverage but you don't have the Cadillac coverage, you know, is that better? I think in Minnesota and where we are right now, that seems to be one of the issues.

We have a Commission that is reporting back to our legislature next year, and that is going to be one of the issues. So that is one of the things we are pushing, other health plans, and many employers.

The CHAIRMAN. Thank you very much.

[Additional statements and material submitted for the record follow:]

NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS
STATEMENT TO THE
SENATE LABOR AND HUMAN RESOURCES COMMITTEE
HEARING OF APRIL 6, 1990

The National Association of Health Underwriters (NAHU) is a professional association representing approximately 10,000 health insurance agents, brokers and producers from across the United States. Our members are dedicated to the marketing and servicing of health and disability insurance to employers and individuals.

Our members offer a unique perspective to the solution of health care access in America. On a daily basis, their work directly touches all of the components within the health care cycle - from the insurance carrier for product development, underwriting decisions and claim experience; to individual employers in the packaging of benefits to meet specific needs; to the employee who may encounter difficulties with coverage or claim issues; and also many times as an advocate between the individual or insurance carrier and the medical provider.

Therefore, we believe our association is well equipped to offer testimony to the Senate Committee Hearing.

The Pepper Commission Recommendations

We commend the Pepper Commission members and staff for their diligent work on one of our nations most complex issues - that of the reported 31 to 37 million Americans who lack health insurance coverage. We share the Commission's goal to provide health care access to all Americans. In this regard, we offer our comments and reactions to specific Pepper Commission recommendations in relation to our position on health care access for America.

Small Business

NAHU supports the cause of the small business owner and employer. These entrepreneurs are the clients of a vast majority of our members. We support the Commission's recommendation to eliminate state mandated benefits for small groups. The number of state mandates has tripled since 1975. These benefit mandates have increased the cost of providing health insurance beyond the means of many small businesses.

In addition, we promote the 100% deductibility of health insurance premiums by all business entities regardless of legal structure. Sole proprietors and partnerships should receive equitable tax preference for providing health insurance to their employees.

We thoroughly support certain insurance industry reforms for the health insurance marketplace. Such reforms especially assist the small employer. We applaud the Commission's recommendation to expand managed care options to all size employer groups. We believe small employers and their employees should share in the savings associated with such cost containment measures.

We further support the concept that individuals should have the freedom of employment mobility without the insurance penalty for pre-existing conditions once that individual has entered the insurance market. Additionally, all individuals within an employer group should receive coverage regardless of medical conditions. In this regard, we promote the concept of state risk pools or private reinsurance mechanisms to spread high risk cases among all coverage providers and risk takers within a state.

We are disappointed with the Commission's recommendation to mandate employer coverage. We oppose the inclusion of an employer mandate in any solution to health access in America. An employer mandate would result in lost jobs and a reduction in the number of new jobs. An employer mandate directly increases the cost of hiring workers and the cost of goods and services produced in the United States. These increased costs reduce the ability of America's small employer to compete with larger businesses as well as in world markets. Simply stated, an employer mandate is bad employment policy, bad economic policy and bad health policy.

We disagree that the regimentation of a standard benefit package be required. We believe the marketplace and each employer, with the counsel of an insurance professional, are better able to structure basic benefit packages which meet the health needs and financial capabilities of the employer.

In this regard, we also oppose a fixed employer contribution amount or percentage. Many small employers cannot afford to pay 80% of the total employee and dependent premium cost, while some that may wish to contribute more may lose the motivation to do so. We acknowledge that for certain low-income Americans, the expansion of certain entitlement programs may be necesssary to cover an individual's contribution. We believe, however, that the market driven nature of employee benefits can produce affordable contributions levels for employers and employees.

Quality Assurance and Liability Reform

We firmly believe that each segment within the American health care cycle must participate in the solution to the health care access problem. Thus, we look forward to the development of treatment practice guidelines for physicians. In addition, we promote uniform reimbursements for institutional medical providers within rural and urban locations.

We share the Commission's concern over the medical malpractice crisis in America and welcome medical malpractice reforms. We believe, however, that the solution must go beyond merely studying the situation. Federal law must assist in the control of liability costs by placing caps on the amount of non-economic damages which juries may assess. We endorse Senate Bill 1274 and request the Commission consider its provisions for liability reform.

NAHU Seven-Point Strategy and Distribution Methodology

NAHU has embodied its proposals for a solution to the health care access problem in America within a Seven-Point Strategy. This Strategy is attached to our statement here today and we would ask that it be made part of the record.

The Pepper Commission does not specifically address the role of the professional health insurance agent, broker and producer. The issue of distribution methodology must be addressed. We oppose an increased and increasing role for the federal government in the definition and distribution of health care insurance. We believe that the delivery of truly cost-effective health care can only be achieved through an individual analysis of the unique characteristics of each employer's circumstances and conditions. This premise has, in fact, previously been supported by Congress, through the Employee Retirement Income Security Act (ERISA) which minimizes regulatory intervention in plan design for self-insured employee welfare benefit plans.

The insurance professional is a necessary and vital resource, acting as employer advocate in designing and delivering plans consistent with the employer's financial and service priorities and performing such critical functions as:

* assisting the employer in the definition of company insurance needs;
* helping the employer establish insurance coverage priorities;
* using the information garnered from the employer to investigate a variety of insurance carriers and a diversity of benefit plan options, thus effectively providing a match of individual needs and priorities to plan design; and

- acting as the representative of the employer to efficiently implement the benefit plan and administration.

In addition, very few, if any, small employers would be able to employ full time benefits manager to provide the above employer functions without significant and prohibitive costs. The insurance professional also provides a vital liaison and advocacy function for the employee, including:

- educating the employee regarding the features of his/her plan;
- clarifying the specifics of the benefit provisions in the plan that are designed for the employee's specific insurance needs; and
- insuring that each employee is aware of procedures for filing claims with the insurance carrier or other private sector third party payor.

The insurance professional serves the employer and employee through direct communication to the carrier, acting as their advocate in situations of:

- administrative disputes between medical provider and employer and/or employee; and
- resolution of potential claim disputes to insure employee coverage and/or compensation.

The insurance professional plays a unique and most critical role providing an irreplaceable resource to the small employer.

Conclusion

The National Association of Health Underwriters recognizes the need to devise a plan to effectively insure fair access to health care and health insurance for all Americans. We promote the free enterprise system and its inherent flexibility and choices for the American population. We disagree with an increased and increasing role for the federal government in the definition and distribution of health care and health insurance.

The Pepper Commission recommendations provide a starting point for serious discussions. Our association stands ready to participate in these discussions. We are pleased to provide this statement and welcome future opportunities to participate in the evolution of future health care policy decisions.

National Association of Health Underwriters

SEVEN POINT STRATEGY
FOR
HEALTH CARE IN AMERICA

Preamble: The National Association of Health Underwriters (NAHU) herein proposes a Seven Point Strategy for health insurance access in America. This Strategy preserves the free enterprise system which presently funds the needs of 84% of the American public. Additionally, the Strategy promotes the expansion of this system to include the reported 31 million Americans that are without health insurance.

The cornerstone for effective health insurance access is our membership of professional agents, brokers and companies. The presence and inherent value of the agent delivery system is therefore deemed explicit to the implementation of this Strategy.

1. Tax Fairness Adjustment.

Tax incentives, in addition to full tax deductibility, should be given to all Americans, including Subchapter S corporations, partnerships and sole proprietorships, as an encouragement to become insured. Corporate employers should continue to receive full tax deductibility for health care insurance purchases. Additional consideration should be given to other tax base changes that would promote the purchase of private health insurance; i.e., full deductibility of all health insurance premiums, and/or a system of tax credits and rebates on a revenue neutral basis to assist lower income Americans.

2. Safety Net Coverage - Medicaid Coverage Expansion.

Consideration should be given to a fiscally responsible expansion of the Medicaid system so that it would encompass the population of Americans whose current income levels do not exceed 150 to 175% of the federal poverty level.

3. Mandatory State Risk Pools for Funding Uninsurable Situations.

Statewide risk pools must be established in every state for the medically uninsurable. These must be funded by proportionate assessment on insurance carriers, HMO's, self insurance plans, health care service plans and all other risk takers operating within that state.

4. Limit Medical Malpractice Awards.

Limit medical malpractice suits to the actual damages or to actual damages plus a pre-set limit on any punitive damage awards. This limit should be sufficiently low so as to reduce the escalating cost of malpractice insurance and discourage excessive suits hoping for a windfall settlement or large attorney fees, and should not be able to be overridden by state laws or state regulations.

5. Uniform Minimum Health Care Insurance Policy Provisions for All Americans.

Free enterprise should determine the insurance benefit provision levels available to insureds. The current system of state regulations over health care insurance provisions requires an expense that could be lessened by a common minimum benefit provision structure nationwide. Higher levels of benefits could be purchased on a qualified tax deductible basis.

6. Medical Services Reimbursed by DRG (Diagnosis Related Groups) Schedules Adjusted for CPI (Consumer Price Index).

Doctors and hospitals should agree to reimbursement based upon expanded DRG payment schedules with inflationary increases tied to the CPI. All payors for health care services, including Federal and State governments, insurance carriers, HMOs, health care service plans, and self-insured plans would utilize these reimbursement schedules for the elimination of cost shifting.

7. Uniform Funding for Institutional Medical Providers.

Common funding for all hospitals, skilled nursing facilities and extended care facilities regardless of their geographic location should be considered immediately so as to provide financial reimbursement equity for like services rendered.

- END-

APPWP
Association of Private Pension and Welfare Plans

APPWP COMMENTS ON RECOMMENDATIONS BY THE U.S. BIPARTISAN COMMISSION ON UNIVERSAL HEALTH CARE AND THE BICOMMITTEE BIPARTISAN SENATE WORKING GROUP ON UNIVERSAL ACCESS ON HEALTH CARE OPTIONS

The Association of Private Pension and Welfare Plans (APPWP) is pleased to submit these comments on health care policy options being developed by a special working group of Senators interested in drafting legislative solutions to America's health care problems. These options, developed under the leadership of Sen. Donald Riegle, Chairman of the Senate Finance Subcommittee on Family Health and the Uninsured, also include recommendations developed by the U.S. Bipartisan Commission on Universal Health Care, also known as the Pepper Commission, and chaired by Sen. John Rockefeller, who also chairs the Finance Subcommittee on Medicare and Long Term Care.

The APPWP is the national trade association for companies and individuals concerned about federal legislation and regulations affecting all aspects of the employee benefits system. The APPWP membership of over 400 companies represents the entire spectrum of the private pension and employee benefits community: Fortune 500 companies; banks; insurance companies; law, accounting, consulting, investment and actuarial firms. APPWP member companies provide or manage health care benefits for millions of American workers and their families.

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The APPWP commends the hard work and dedication reflected in both these groups' reports, and the commitment of all involved to resolve, in various ways, the many problems confronting America's health care system, the people who pay for the system, and the people who are left out of the system.

The Pepper Commission is to be commended for completing its arduous task of identifying and determining the costs for resolutions of each major problem in the U.S. health care system. For the first time, we have a comprehensive idea of the public and private costs to American taxpayers and business for a major overhaul of the system. We do believe, however, that the costs may be underestimated in many instances.

We are also gratified that the Commission and the Working Group believe that the best way to improve on U.S. health care delivery is to build on the current employer-provided health care system. Today 85 percent of U.S. workers and their families enjoy the security of health care coverage provided through the workplace. (For full-time workers, the number is 90%.) American employers, responding both to tax incentives that have wisely been installed and reinforced by successive Congresses and Administrations, and to their concerns for their employees' well-being, have built a strong and flexible network of health care for millions of Americans.

We regret, however, that the Commission chose to base many of its reforms on mandating health care coverage on employers, by specifying what those mandated benefits should be, and by giving short shrift to health care cost management, a promising solution to the never ending cost spiral of health care in America. The APPWP also believes that greater encouragement to private sector solutions for long term care should have been emphasized in the Commission's recommendations rather than the expensive and multi-layered public program proposed.

The APPWP is not alone in believing that the hefty price tag for the Pepper Commission proposals is one that the public is not yet ready to pay. The boldness present in the Commission's sweeping recommendations was lacking when it came time to suggest how the bill was to be paid.

We applaud the Working Group for including a wide spectrum of policy solutions, including those of the Pepper Commission, in its report. We will comment below on those proposals we think have merit and that should be explored further, as well as those ideas that we think are not workable or that should be abandoned. The APPWP recognizes that the solutions to the problems are complex and intricate.

The wishes of private employers have been greatly misrepresented of late. Like so many others, employers are looking to the federal government for leadership in setting national health care policy and in controlling the costs of delivering health care. They are not seeking national health insurance. Employers, like the states, are growing impatient for action. Those who are looking for a comprehensive top to bottom reform of our health care system must be patient; the political will for such a revolution is still years away. However, there is much consensus on reforms that can be enacted now: malpractice reform, small employer insurance market reforms, Medicaid expansion, cost management and constraint of provider charges, setting a deliberate agenda for outcomes research and practice guidelines.

The APPWP asks Congress, "why wait?"

The Dilemma for U.S. Business

Corporate America is only just coming to grips with the staggering costs of providing their employees and families with health care coverage. We know all too well the litany of statistics that describe the stunning growth in health care costs, both in the absolute as well as a proportion of GNP over the last three decades. We also know that as a nation we spend more proportionately on health care than all other industrialized nations, yet we are a less healthy people.

The dilemma for U.S. businesses is critical. If company pre-tax profits and health care costs grow at the same rate they did between 1985 - 1988, those costs will outstrip profits in just twenty years, or if health care costs grow at the rate they have over the last twenty years. Health care costs impede many U.S.-based multinational companies in their ability to compete effectively with companies abroad whose countries have much lower health care costs, and where those costs represent a much lower proportion of goods and services produced.

In addition, proposed changes ahead in accounting standards will mean that companies will have to reflect on their financial statements promised health care benefits to retired workers -- a staggering drag on future financial performance. Companies therefore face similar threats from the health care cost monster as does the federal government, where Medicare will probably run out of money before this decade is through, and which will surpass Social Security in outflow before too long. States, too, are reeling under Medicaid costs that they fear are swallowing their budgets and impeding their ability to deliver other much needed services to their citizens.

The APPWP's Principles on Expanding Health Care Coverage

The Association of Private Pension and Welfare Plans, through its Health Care Issues Committee, has developed a set of guiding principles on expanding health care coverage. The APPWP believes that expanding coverage to the uninsured is sound public policy, as it would extend to all Americans vital health care protection, and also because it would eliminate many inefficiencies, and associated, significant costs, in health care delivery that is shifted like a hot potato among different payors.

The APPWP believes that the best way to expand coverage to the over 30 million uninsured is to devise and enact appropriate solutions for each different group of uninsured.

The APPWP strongly opposes a mandated benefits solution to the employed uninsured population because it will burden unfairly many companies, particularly small and marginal businesses, and thus reduce the number of jobs available, especially to lower income individuals. Mandates also reduce flexibility for all employers in the design and provision of benefit packages, and add unnecessary complexity and cost to the operation of businesses, which would prove especially detrimental to marginal operations. It is not the worth of any particular benefit that we debate; rather we reject the intrusion of the federal government in the process of establishing benefits. Dictating specific benefits leads to poor utilization of health care and it interferes with effective cost containment.

The APPWP supports expanding coverage through further incentives to private employers, particularly small business, and through efforts to make the cost of insurance more affordable. Many of these ideas and incentives are spelled out by the working group and include: pre-emption of state mandates; subsidies to small businesses offering coverage for the first time; establishment of high risk pools for uninsurable individuals; voluntary improvements such as those suggested by the Health Insurance Association of America that would reform the small employer insurance market, and expanding the premium deduction for the self-employed. Medicaid should be improved and expanded to provide coverage to those with no attachment to the workforce, and by subsidizing employee premium co-payment for the working poor. Other tax incentives to small or marginal employers should be developed to expand insurance coverage.

Pre-emption of state health mandates would reduce health care costs in a number of ways. Since 1965, over 800 different benefit mandates have been passed by the 50 states. Too often, these mandates serve only the purposes of special interest groups. Companies that want to offer health insurance (that is not self-funded) to their employees must comply with these various mandates and therefore lack the flexibility to offer plans most appropriate to their workforce as well as sensitive to their fiscal requirements. Uniform regulation of employee benefits will foster greater coverage.

States should be encouraged to develop health insurance high risk pools that provide coverage to those people who are uninsurable because of health conditions. Eligibility should be limited to those who are ineligible for public insurance coverage, cost containment methods must be incorporated, benefit design should be flexible, and financial losses of the pools should be spread over the broadest possible base.

Recommendations on Long Term Care

America's health care crisis is no more apparent than when a family is impoverished due to the costs of providing extended care for a loved one whose ability to function independently is severely limited. As we learned last year, what America's retirees want is a national policy on long term health care. It is unclear, however, who will pay the price associated with the Pepper Commission's costly and complex proposals.

The APPWP believes that more cost-effective, targeted, and private-sector provided solutions to the problems of long term care should be encouraged by federal tax policies. The development in the marketplace of new long term care "products" is only just beginning. Federal tax policies in the past wisely gave rise to a magnificent system of employer-provided health care and retirement income benefits for millions of working Americans. New ways of looking at some of those incentives are evolving and will produce long term care benefits and security if government has the foresight to provide adequate incentives and the wisdom to refrain from thwarting such efforts. As with other tax-preferred benefits, the provision of new long term benefits will be cost-effective to the Treasury and equitably available to beneficiaries.

A recent Treasury Department report on financing options for long term care merits further study and consideration by the Congress and private employers. Treasury proposes, for example, that employers be allowed to offer pension beneficiaries modest reductions in current benefits in exchange for long term care benefits if needed. Such benefits would be treated as pension benefits for purposes of pension funding rules. Treasury also recommends that the tax treatment of long term care benefits be clarified and made consistent with other retirement income benefits. Sen. Robert Packwood and Rep. Rod Chandler have introduced legislation that would permit employer pre-funding of long term care benefits; this bill also deserves serious consideration. The APPWP is willing and able to work with policy makers in fashioning workable and cost effective solutions to the long term care problem.

A 1987 report by the Long Term Health Care Policies Task Force in the Department of Health and Human Services recommended forty-one options to expand long term care coverage. The APPWP urges Congress to seriously consider a number of proposals developed by the Task Force. The Task Force, like the Treasury Department, suggested that long term care insurance be promoted through employment by way of tax incentives for employers and by adoption of cafeteria plans and flexible spending accounts. The Task Force also suggested that beneficiaries be permitted to use vested, retirement assets to purchase long term care insurance without tax penalty. The Task Force also urged clarification of the tax status of long term insurance reserves.

Recommendations on Cost Containment

The high cost of health care drives all other health care problems: more Americans would be covered and secure from financial disaster due to a severe illness if the cost of health care were not so prohibitively high. The APPWP strongly believes, therefore, that attacking the health care cost monster should be the first order of business for a national health care policy. Almost all cost containment proposals should be considered and implemented as appropriate.

In particular, the APPWP urges that managed care provisions be included in all health plans. Legal and regulatory obstacles preventing employers, insurers and providers from adopting managed care features, especially with respect to state regulatory obstacles, should be overcome. In many states, special interest groups have urged passage of various measures that together would frustrate development and adoption of contract provider networks, such as preferred provider panels or networks, by corporate sponsors trying to reduce medical costs throught volume/discount contracts. Similar efforts to thwart utilization management and other cost-savings features of alternate delivery systems have accelerated in recent years.

Medical malpractice reform is urgently required: standards of negligence should be amended, juries should be barred from determining damage awards, contingency fees should be constrained.

As stated previously, the APPWP supports federal preemption of state mandates and reform of the small employer insurance market. Long term strategies and encouragement of innovative cost control methodologies are needed, especially to constrain the costs of health care providers. Broader application of 1989 physician payment

The CHAIRMAN. The committee stands in recess.

[Whereupon, at 12 p.m., the committee was adjourned.]

reforms under Medicare should be explored. Further federal support of outcomes research and practice guidelines must be accelerated. Even in the face of protracted contract disputes, efforts to make covered individuals more sensitive to cost must continue by private employers. Better and more accessible data on cost and quality for health care consumers must be expanded rapidly.

Conclusion

There is much wrong with America's health care system, but there is also much more that is commendable. The APPWP believes that fundamental reforms are a long way off because there are strong differences of opinion as to how best to proceed. However, as we stated at the outset, there exists strong consensus in many key sectors of reforms that can be enacted today. Such changes are incremental, but together they would bring significant improvement in the areas of cost control and coverage growth. It would be unwise to postpone action.

The APPWP also urges policymakers not to seek financing reforms by taxing or capping the tax preference of employer-provided health insurance. Congress and the Administration should instead look to greater private sector incentives to expand much needed health care coverage to more working Americans.

April 17, 1990

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